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ABSTRACT

This fact sheet contains information relating to drug abuse and abusers; drug traffic legislation; law enforcement; and descriptions of commonly used narcotics, stimulants, depressants, and hallucinogens. Also included is a short but explicit listing of audiovisual aids, an annotated bibliography, and drug identification pictures. The booklet concludes with a description of the Special Action Office for Drug Abuse Prevention. (RWP)

fact sheets

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DRUG ENFORCEMENT ADMINISTRATION

UNITED STATES DEPARTMENT OF JUSTICE

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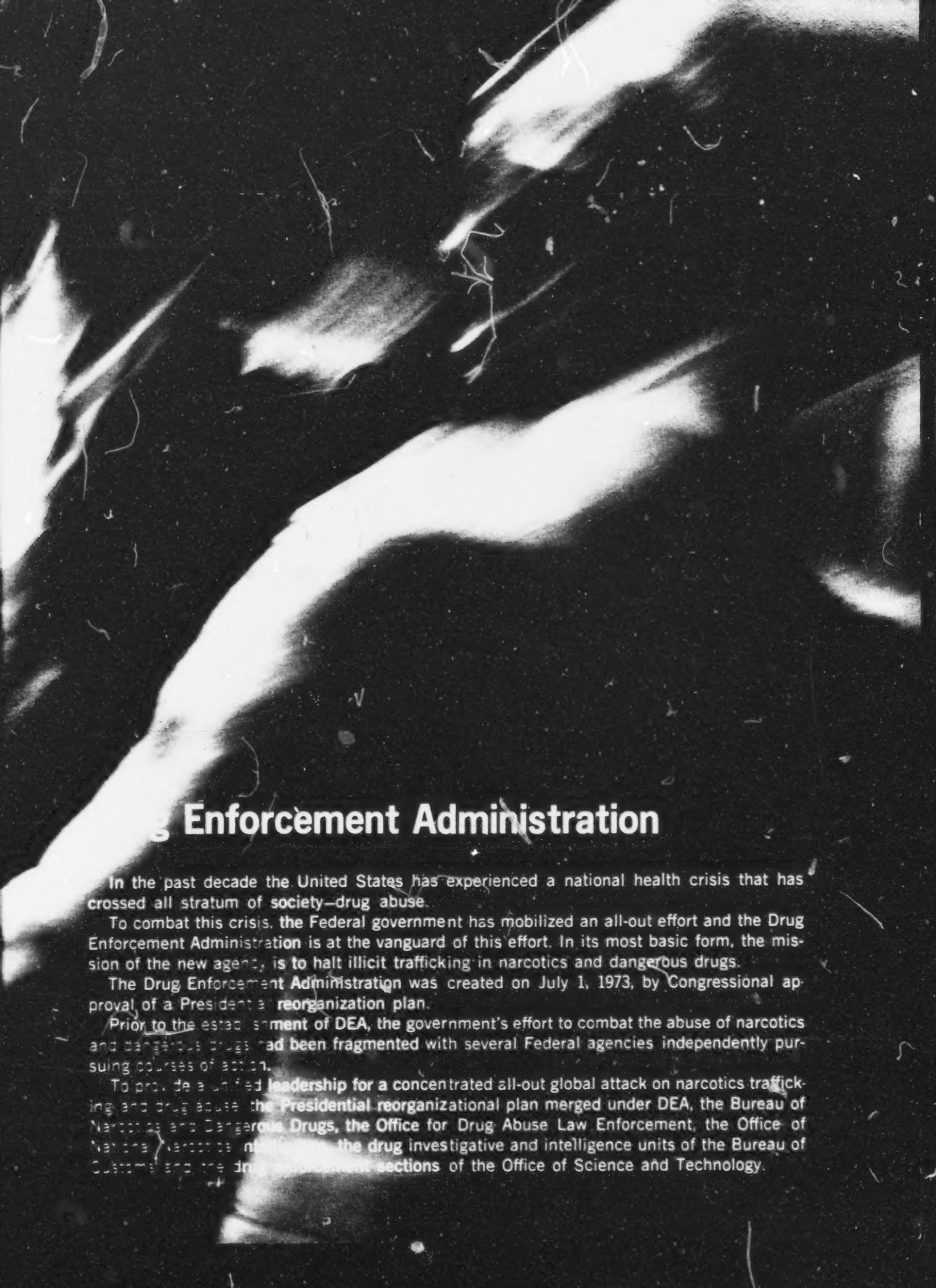
ILLUSTRATION:
The Poppy Pod. The scoring, which is done [illegible], enables the crude opium to ooze which is later scraped off and formed into [illegible]



Enforcement Administration

In the past decade the United States has experienced a national health crisis that has crossed all stratum of society—drug abuse.

To combat this crisis, the Federal government has mobilized an all-out effort and the Drug Enforcement Administration is at the vanguard of this effort. In its most basic form, the mission of the new agency is to halt illicit trafficking in narcotics and dangerous drugs.

The Drug Enforcement Administration was created on July 1, 1973, by Congressional approval of a President's reorganization plan.

Prior to the establishment of DEA, the government's effort to combat the abuse of narcotics and dangerous drugs had been fragmented with several Federal agencies independently pursuing courses of action.

To provide a unified leadership for a concentrated all-out global attack on narcotics trafficking and drug abuse the Presidential reorganizational plan merged under DEA, the Bureau of Narcotics and Dangerous Drugs, the Office for Drug Abuse Law Enforcement, the Office of National Narcotics Intelligence, the drug investigative and intelligence units of the Bureau of Customs and the drug enforcement sections of the Office of Science and Technology.

Enforcement

In the field of drug law enforcement, principal emphasis is placed on the source and distribution of illicit drugs rather than on the arrest of drug abusers. The DEA's basic emphasis in enforcement of the law has been in stopping the flow of drugs at their foreign sources, disrupting the illicit domestic commerce at the most organized level and assisting state and local police to prevent illegal drugs from reaching the community level.

To accomplish these goals, DEA is responsible for development of an overall Federal drug strategy through workable programs, planning, evaluation and intelligence.

The DEA is also charged with full investigation and preparation for prosecution of suspected violators of Federal drug laws and conducts relations with law enforcement officials of foreign governments, under the policy guidance of the Cabinet Committee on International Narcotics Control.

To perform its mission the DEA has stationed highly trained agents in all the major cities throughout the United States and in 45 offices in 31 countries throughout the world.

The objectives of DEA agents are to reach the highest possible source of supply and to seize illicit drugs before they reach the abuser. They achieve this goal by employing the most advanced enforcement techniques and use of modern technology and equipment.

The Drug Enforcement Administration is also responsible for the regulation of the legal manufacture of drugs and other controlled substances under the Controlled Substances Act of 1970.

Under this act DEA is required to establish import, export and manufacturing quotas of various controlled drugs. Physicians, pharmacists and other persons handling, dispensing, or prescribing controlled drugs are subject to periodic inspections by DEA representatives. These controls assure an adequate legal supply of drugs for medicine and research and at the same time prevent diversion of drugs at the illegal traffic.

Intelligence

Intelligence is an essential element in the success of any enforcement agency. DEA has an Office of Intelligence staffed by experienced Criminal Investigators and Intelligence Analysts. Each DEA Regional Office in the United States and in foreign countries has a Regional Intelligence Unit. All information concerning narcotics and dangerous drugs trafficking organizations and individuals is furnished to the Office of Intelligence where it is collated, analyzed, and disseminated in form of a finished intelligence product.

The information provides the Office of Enforcement with actionable intelligence which will enable them to attack the traffic in a systematic way by selecting areas of vulnerability. It also provides the Administrator and other U.S. Government agencies with strategic intelligence information for policy determination, deployment of resources and the development of an overall strategy. Intelligence on shifts in the traffic and type of drugs abused and effectiveness of foreign and domestic programs are all part of this intelligence process. An important facet of the DEA intelligence program is the continuing exchange of information with other Federal, state and local, as well as foreign, law enforcement agencies.

Training

The Administration's National Training Institute conducts intensive training in narcotics and dangerous drugs law enforcement for law enforcement officers from agencies throughout the U.S. and the world. Ten-week schools are conducted in which police officers receive training similar to that which DEA Special Agents receive. In addition to intensive practical instruction in drug law enforcement techniques, they are introduced to management concepts which will enable them to develop and lead drug investigative units. Specialized two-week schools offer 80 hours of instruction to state, county and city officers in the basic techniques of narcotics and dangerous drugs investigation. These schools are held at the Administration's National Training Institute in Washington and at field locations throughout the U.S.

DEA has intensified its efforts in the area of international training. The National Training Institute conducts intensive, practical training programs in foreign countries designed to satisfy the needs of the recipient nation and assist the Administration's international enforcement mission. The programs, ranging from two weeks to a month, are presented in the native language of the participant and are heavily reinforced with practical exercises which utilize the most so-

phisticated enforcement techniques and equipment. DEA also conducts multi-language practical training programs for selected police officials of foreign nations. These schools provide extensive instruction in drug law enforcement techniques, intelligence gathering, and training to prepare participants to effectively lead the efforts of cooperating nations in the international drug interdiction effort. Qualified English speaking officers also participate in Ten-Week Police Training Schools.

Special seminars and briefings are conducted for forensic chemists, other Federal agencies, civic groups, foreign dignitaries and other visitors at the institute and at various locations in the U.S.

Science and Technology

In an attempt to accumulate up-to-date information regarding the drugs under its jurisdiction, the Administration encourages controlled scientific research in the field of drug abuse. DEA's research is confined to information gathering which will aid law enforcement agencies to better cope with the drug abuse problem and its related aspects. Research encompasses clinical, social, psychological, and biological research. The Administration, as part of its scientific staff, employs physicians, pharmacologists, chemists, statisticians, pharmacists and professional educators.

Another function is that of the Science Services Division which has the responsibility for administering the six regional laboratories and the Special Testing and Research Laboratory which comprise the DEA laboratory system.

Regional laboratories are operated in New York, New York; Washington, D.C.; Miami, Florida; Chicago, Illinois; Dallas, Texas; and San Francisco, California. The Special Testing and Research Laboratory is in McLean, Virginia.

Virtually all controlled substances cases require physical evidence for their successful prosecution. It is the primary function of the laboratories to provide definitive identification of such substances, and to provide expert testimony in court. Much of the evidence can also offer valuable clues to assist in the investigation of drug traffic patterns. The laboratories provide in-depth analysis of characteristics of evidence. The laboratories also have the capability of fingerprint processing and photographic printing and development.

Drug Abuse Prevention

Drug abuse prevention is another area of responsibility for the Drug Enforcement Administration. As part of its program to make citizens aware of the hazards of narcotics and dangerous drugs, the agency provides factual information through literature, speakers, films, and displays to a variety of organizations. DEA also works closely with educators, as well as with local, state and national Government agencies, law enforcement officials, and organizations in planning and conducting abuse prevention programs. An effort is made to conduct these activities at the regional level whenever possible.

Law Enforcement Assistance

Cooperation between all levels of enforcement agencies has been a key factor in the planned attack on narcotics trafficking. DEA agents actively assist state and local police through task forces and Metropolitan Enforcement Groups (MEG). The task forces are designed to concentrate enforcement efforts on drug trafficking organizations or individuals operating in a specific region. The MEG groups merge the efforts of various local police in planning, intelligence and enforcement in a designated area.

Public Confidence

There is another key element in the overall mission of DEA . . . maintaining public confidence. John R. Bartels, Jr. DEA Administrator, in July 1973 issued a new statement of policy governing the conduct of all Federal narcotics agents. He emphasized the importance of this element by saying: "Public confidence can only be earned by the professional conduct of every agent—no matter how challenging and difficult the circumstances. There is no more difficult area of law enforcement than the suppression of the narcotics traffic. The Drug Enforcement Administration is taking firm steps to insure public confidence in DEA and the integrity of its personnel will be a continuing asset in our all-out effort to enforce the law and solve the nation's drug abuse problem.

2

Illegal Traffic in Narcotics and Dangerous Drugs

The United States does not grow opium producing poppies. Yet the by-product of these poppies, heroin, has caused a devastating epidemic of addiction in the United States.

The Pattern of the Poppy

The Drug Enforcement Administration's primary mission is to halt this epidemic through law enforcement and preventive programs.

American heroin addicts are the victims of the most profitable criminal enterprise known to man. They are the final link in a chain of secret criminal transactions that begin in poppy fields of Asia, pass through clandestine heroin laboratories in Europe and Asia and enter the United States through a maze of international smuggling routes. The chain is made up of profit motivated individuals from the peasant farmer to international criminals, Corsican gangsters, Chinese merchants and organized crime figures.

Almost all of the world's illicit opium is grown in a narrow belt of mountains that stretches along the southern rim of the great Asian land mass. This opium producing belt extends from Turkey's Antolian plateau, through the northern reaches of the Indian subcontinent, extending to the remote mountains of Burma, Thailand and northern Laos.

Heroin is a chemically bonded synethese of acetic anhydride, a common industrial reagent and morphine, the basic alkaloid extracted from the opium poppy. In the Fall or early Spring, the poppy farmer plants his crop. About three months after planting, a brightly colored flower is produced. Gradually the petals drop from the flower exposing an egg-like pod. The farmer makes a series of parallel incisions across the pod from which oozes a white milky sap. The opium sap turns to a brownish colored gum and the farmer harvests it by scraping it off with a dull knife.

The opium is converted to morphine in a relatively simple chemical process that usually takes place in a makeshift lab close to the poppy fields. It takes about 10 pounds of opium to produce one pound of morphine. Morphine is converted to heroin at a one to one ratio.

In 1973 there are four major supply complexes of illicit opium and its derivatives, morphine and heroin.

The primary complex involves Turkey, France, Western Europe, South America, Canada and the United States. The second complex is the "Golden Triangle Area" consisting of the remote border areas of Burma, Thailand and Laos through shipping points in Bangkok, Hong Kong, Malaysia, the Philippines, Canada and the West Coast of the United States. The third complex is opium produced in India, Pakistan, Iran and Afghanistan. The fourth is Mexico, the supplier of a brown heroin that is seen with persistent frequency in the United States, particularly the west coast and border areas.

The heroin complex originating in Turkey has been the major supplier of Eastern United States cities where the heroin epidemic broke out in the late 1950's and early 60's. International trafficking groups purchase opium from Turkish farmers, convert it to morphine and smuggle it to clandestine laboratories in France via western Europe.

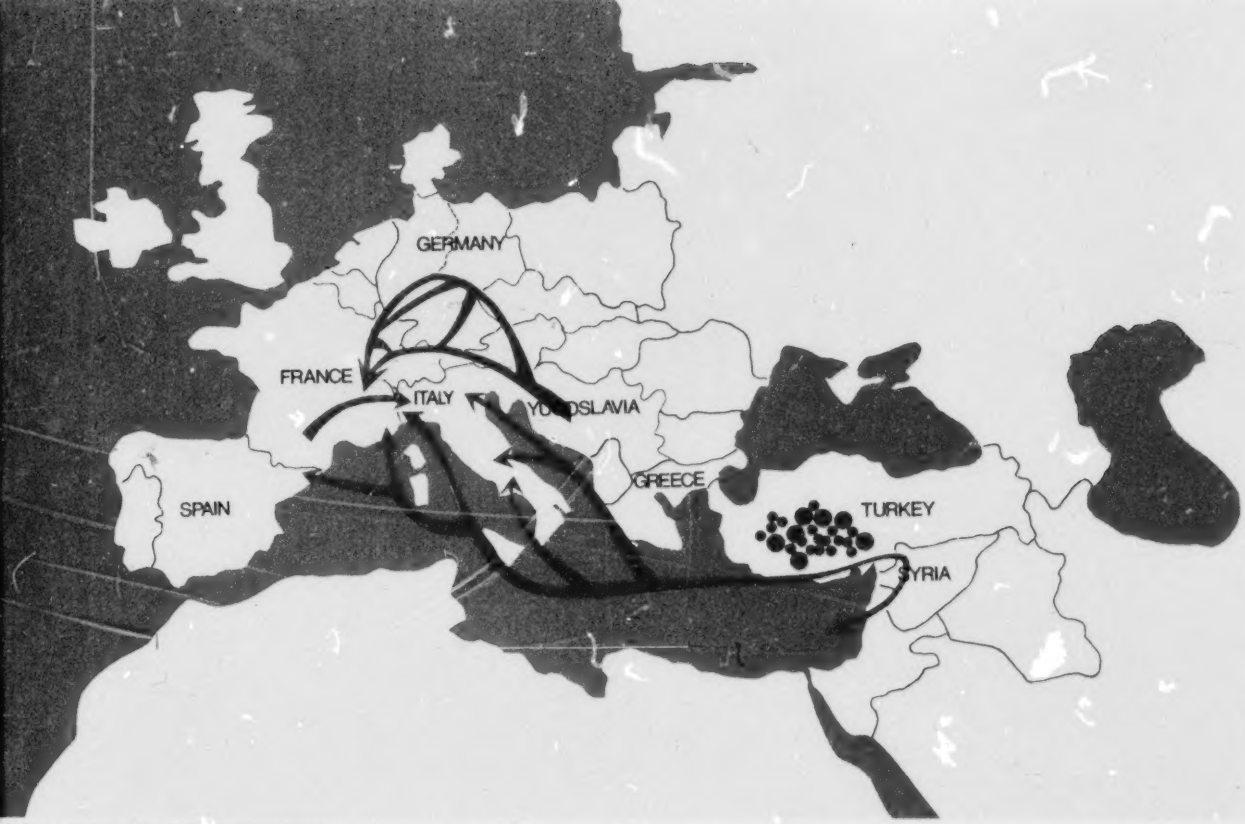
Marseilles was and still is in 1973 a primary city where clandestine laboratories refine morphine into heroin. Within a one year period, French narcotics officers aided by Drug Enforcement Administration agents uncovered five heroin laboratories in the Marseilles area.

In the 50's and 60's international narcotics traffickers carried out negotiations with U.S. based criminals, in many instances organized crime figures, to deliver heroin shipments. Delivery was made either through Canada, Mexico or directly into one of the major ports of entry such as New York or Miami. Later, as DEA agents and U.S. Customs agents traced and disrupted these trafficking routes, South America became a major transshipment point. Expatriate French nationals, Corsican criminals, and Italian nationals living in South America became the nucleus of a loose knit international heroin smuggling operation.

As a result of a concentrated Drug Enforcement Administration effort, increased cooperation of Western European and South America governments, and the banning of poppy growing in Turkey, there has been a major curtailment of this extensive complex.

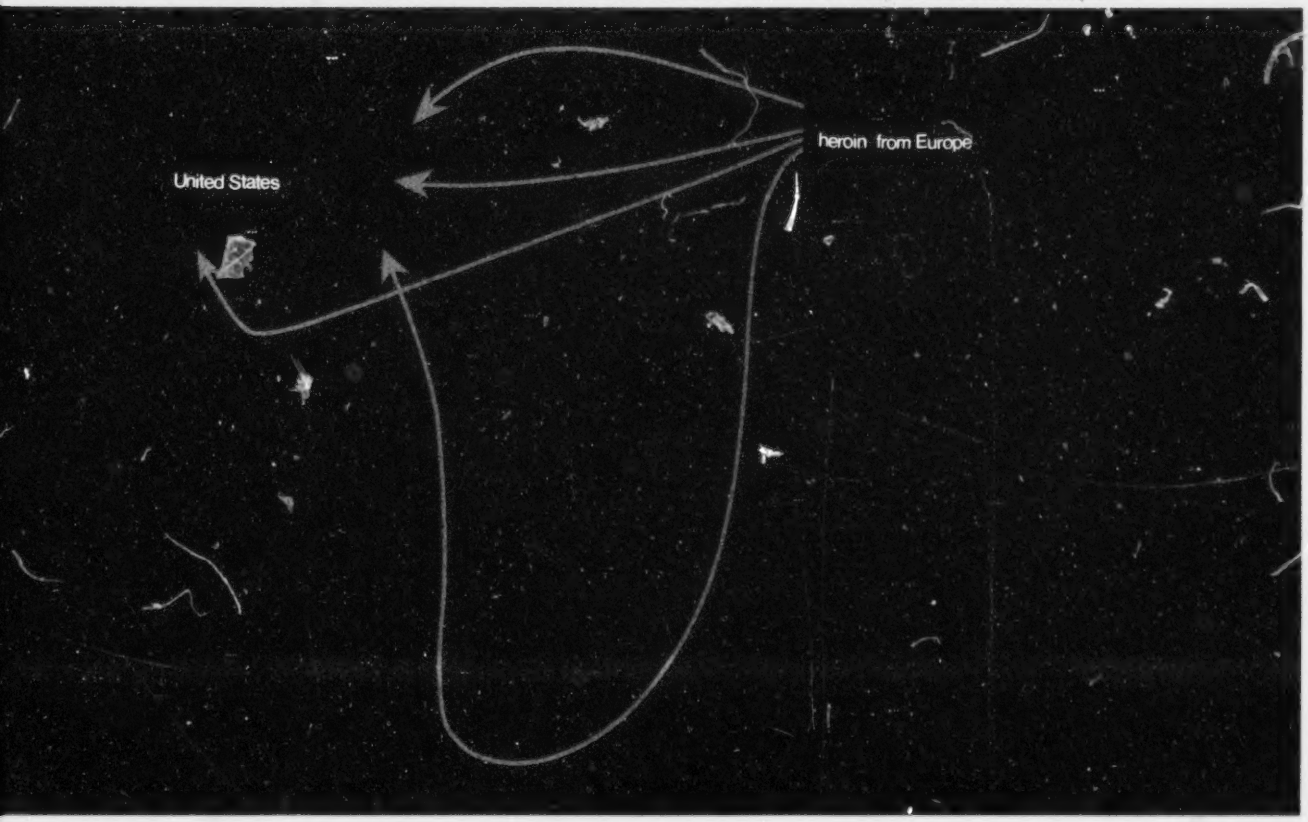
The primary dividend of this multi-lateral effort has been a prolonged period in which the quality of heroin sold on the streets of major East Coast and Middle West cities has dropped in volume and purity while the price has increased.

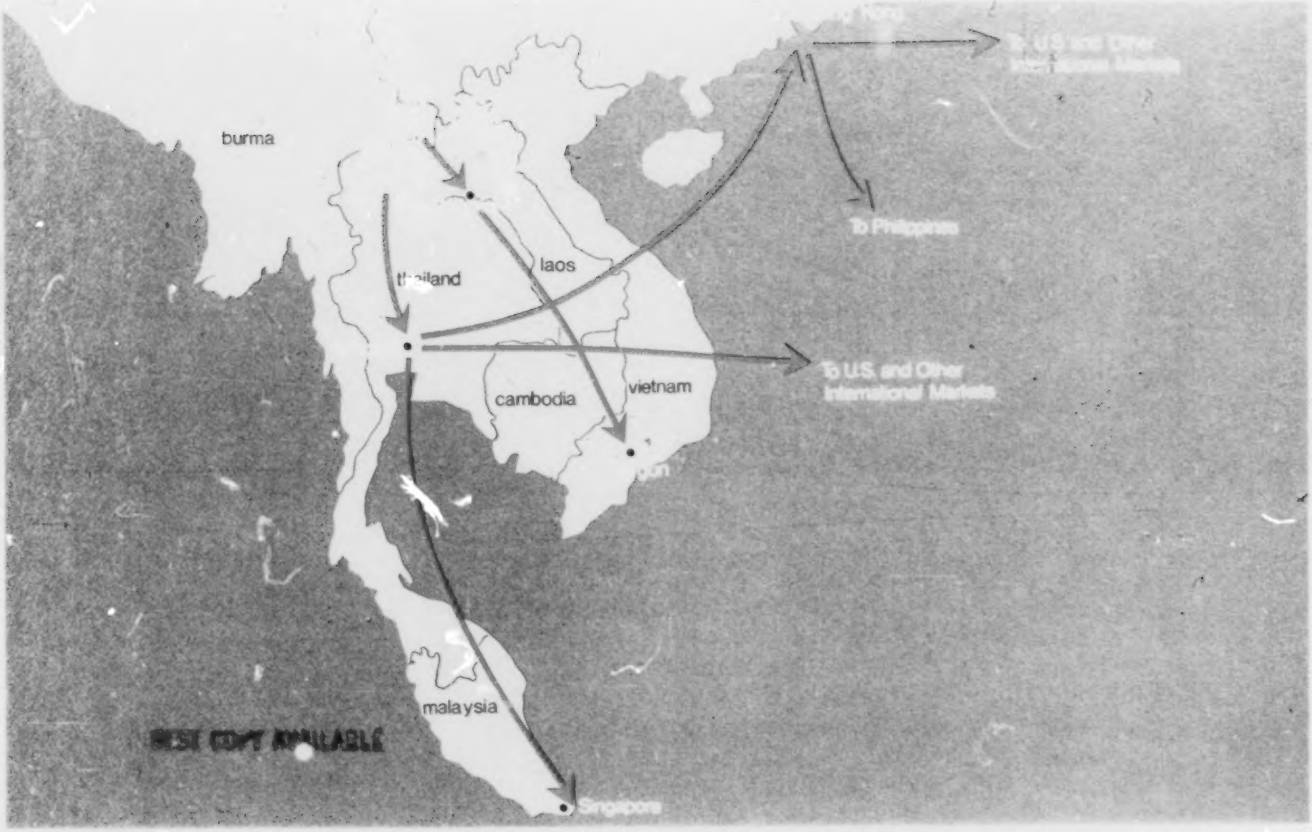
Southeast Asia, the second major opium supply complex, has emerged in recent years as a seri-



THE TURKEY-US NETWORK Heroin Movement Routes from Europe to the United States

THE TURKEY-US NETWORK Opium and Morphine Base Movement from Turkey to Western Europe





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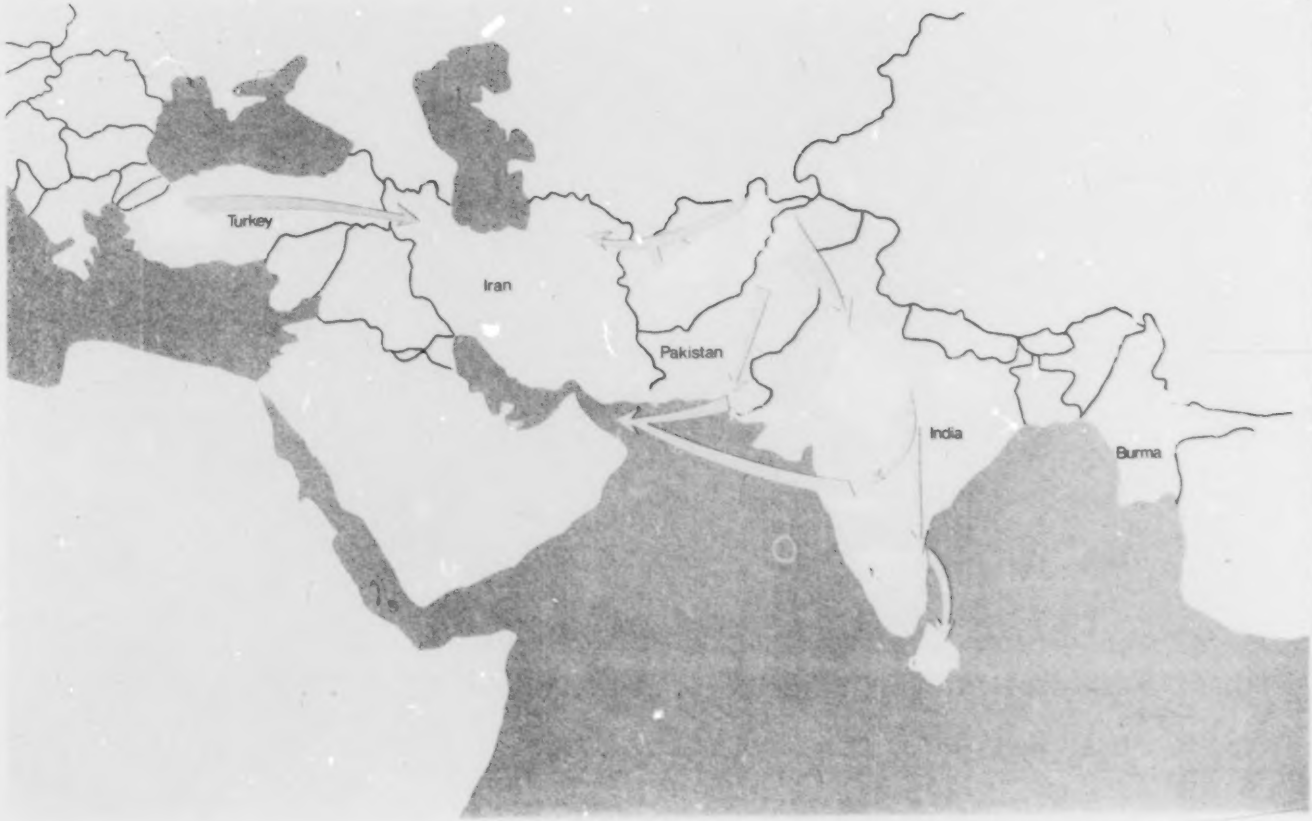


ous potential heroin producing hazard. Opium produced in the remote, rugged mountain area known as "the Golden Triangle" has been the main supply for Asian addicts. The opium, for the most part is converted to smoking opium to supply this localized market.

However, the arrival of large numbers of American troops in Vietnam in the 1960's opened up a new potential market and heroin of high purity became readily available in Saigon and other major Southeast Asian cities.

With the end of the U.S. military presence in Vietnam in 1973, heroin traffickers were saddled with a surplus inventory. The decrease of transportation facilities between Vietnam and the United States also reduced the opportunities to smuggle heroin into this country from Southeast Asia.

At the same time the Government of Laos banned opium production. Thailand has created an effective, special narcotics task force staffed with skilled personnel, many of whom have been trained by the Drug Enforcement Agency. In Burma, the Government has attempted to gain control of its border area in the Golden Triangle from the dissident military bands that have for many years dealt in opium.

In 1973 there is indication that very little, if any, of the opium crop from India, Pakistan, Iran and Afghanistan is converted to heroin for the illicit market in the United States. The quality of Afghani and Pakistani opium is poor with a low morphine content. What illegal morphine that might be produced from these areas would probably follow the Western European trafficking pattern and augment the remnants of the morphine base stocks from Turkey that are refined to heroin in the Marseille region.

Following curtailment during the recent shortage of French heroin, Mexican brown heroin has appeared in some areas in the United States where it has not normally been seen. This lower grade of heroin, brown in color, is usually smuggled across the U.S.-Mexican border and is predominantly available in Texas, Arizona and California. Low grade heroin from Hong Kong and Bangkok known as "number 3" or "Chinese rock heroin" has also appeared in bulk in the U.S. and Europe. However, this heroin supply from Mexico and the Far East has not been sufficient to date to replace the volume formerly smuggled from France.

Drug Enforcement Administration agents have teamed with Mexican Federal police in 1973 in an effort named "Operation Cactus." In this mutual enforcement effort, major Mexican narcotic trafficking rings that had supplied kilograms of heroin, cocaine and marihuana were penetrated and ranking traffickers were arrested.

To assist foreign narcotic control authorities in the suppression of the illicit narcotic traffic effecting the United States, the Drug Enforcement Administration has assigned 154 Special Agents and 109 clerical support personnel to 51 officers in 35 countries throughout the world.

Illicit Market Prices

The clandestine nature of almost all transactions in illicit narcotics markets makes for a dearth of information on costs and prices of opium and its derivatives at each stage of processing and distribution. Enough information is available, however, to provide some insights into the characteristics, price levels, and capabilities for adjustment of some of the major illicit markets.

In general, the illicit markets for opium and its derivatives are seller's markets from which the major suppliers receive extremely high rates of return on their investment. The profits that can be made in servicing the U.S. market for heroin are sizeably greater than in any other market. The following tabulation illustrates the comparative scope for profit in the U.S. market:

Market	U.S. $ Per Kilogram	U.S. $ Per Kilogram of Raw Opium, Equivalent
United States		
Price to Farmer for Opium (In Turkey)	$ 60.00	—
Wholesale Price for Heroin (Marseille)	7,000.00	700.00
Border Price for Heroin (New York)	12,000.00	1,200.00
Wholesale Price for Heroin (New York)	40,000.00	4,000.00
Retail Price for Heroin (New York)	400,000.00	40,000.00

While there is a considerable price mark-up between the wholesale dealer and the retail distributor, the greatest margin of profit is realized

by the wholesale trafficker handling large volumes of heroin.

The price of one kilogram of heroin delivered to a U.S. buyer by a French trafficking group was about $4,000 in 1960. By 1973, the delivery price of high grade heroin had increased to $12,000 per kilogram. This 300% increase reflected many aspects of the illicit trade. Primarily, it indicated that the intensified enforcement effort had increased the risk of dealing in heroin. Secondly, the price increase indicated that because of this all-out enforcement effort the suppliers were unable to fill the demand and, therefore, were able to command premium prices for the amount of heroin available.

On the wholesale level the heroin, once it is cut to boost profits, would bring $40,000. Recut again for street sale, the same kilo of heroin would bring about $400,000 when sold in individual doses. In 1970, heroin on the wholesale level was about 46% pure. By the time it reached the street level it had been cut to 9 or 10% purity. By the Summer of 1973 a kilo of heroin on the wholesale level was about 24% pure and the individual dosage unit had been reduced to between 4 and 5% pure.

The average addict needs about 50 milligrams of heroin daily to sustain his habit. At the going prices the average addict would have to spend $58 a day or $21,112 a year for his heroin supply.

The Marihuana Market

Although Near and Middle Eastern countries are major centers for production of the cannabis plant, from which marihuana is derived, most marihuana in the U.S. traffic grows in Mexico. Large quantities of marihuana, illegally cultivated in Mexico, are smuggled across the border into this country. Occasionally, marihuana grown in the United States is also found in the illicit traffic.

Traffic in Cocaine

The cocaine traffic in the United States begins in the Andes Mountain regions of Bolivia, Chile, Peru, Colombia, and Ecuador where the coca leaf is grown. These leaves are processed into cocaine in clandestine laboratories and then smuggled into the United States through Miami and New York, often in airplane baggage or ship cargo. One important pattern in this trade originates in Peru, travels first through Ecuador and Panama, then to Mexico and the United States. Another route starts in Chile, extends through Latin American to Pacific coast ports and into the United States. A third route can be traced from Bolivia through Brazil to the West Indies and North America.

Illegal Traffic in Dangerous Drugs

A large proportion of amphetamines and barbiturates in the illicit traffic is diverted from legal channels. A portion of illicit amphetamines and barbiturates is smuggled into the United States from Mexico. They may have been produced in secret Mexican laboratories or legitimately manufactured and diverted to Mexico from legally produced U.S. stocks. Other portions of the illegal supply originate through theft and by production in clandestine laboratories, operating illegally in garages, basements, warehouses—even in trucks. Some registered manufacturers, under the cloak of legality, make quantities of dangerous drugs unlawfully and dispose of them through the black market trade. The illegal "bulk" peddler who deals in hundreds of thousands of capsules and tablets, is an important link in the traffic in dangerous drugs.

Since there is no legal production of hallucinogenic drugs in the United States, the illicit traffic depends on productions from illicit laboratories or smuggled drugs from Europe, Mexico, Canada, and Australia.

Distribution and Diversion

Methods of distribution of narcotic and dangerous drugs are similar. Both are transferred from the major trafficker to the distributor, then to the street peddler and finally to the user.

Once the drugs reach the user, the cost has escalated. For example, the same 10 kilograms of raw opium grown and sold to an underworld broker for $350 will produce nearly 45,000 pack-

ets of five percent pure heroin worth $5 each, or a total of $225,000. Pills have their profit too. Stimulants and depressants can be manufactured for approximately one-half to one cent each. On the black market, the going price is about 20 cents for a pill or capsule.

Still, the price of any drug is totally dependent on the location of the user, demand for the drug, availability of the drug, and purity of the drug.

Most narcotics and dangerous drugs (excluding heroin, marihuana, and hallucinogenic drugs) are valuable medicines. Some drugs, such as those used for the common cold, can be sold over the counter. Other more potent substances, including narcotics, amphetamines, and barbiturates, are required by law to be sold only on a physician's prescription. So, the drug abuser has found various ways to obtain his drugs illegally. He may alter the date and dosage of an existing prescription or forge a new one on a prescription blank stolen from a doctor. He may purchase his supply from a truck stop, newsstand, bar, or retail peddler. He may even make arrangements to purchase dangerous drugs without a prescription from otherwise legal sources.

Drugs intended for medicinal use have been diverted into the illicit drug trade by dishonest plant employees, by overproduction, and thefts from supplies in warehouses, hospitals, pharmacies, and persons licensed to handle the drugs.

3
Drug Abuse

The problem of drug abuse is widespread. It involves not just a nether world of criminals and "dope fiends." Many reputable people in the real, close-at-hand world are caught in the web of drug abuse. But the actual cost of the problem is found not just in the number of people lost to a productive society. Drug abuse feeds millions of dollars into organized crime, causes millions of dollars in property loss, and places a burden of responsibility on the rest of society to reclaim its members.

Extent of Abuse

While no one knows how many drug addicts there really are in this country, as of June 30, 1973, some 95,897 active narcotic addicts were recorded. This means there is approximately one narcotic addict among every 2,170 persons. These figures are not intended to represent all addicts. June 30, 1973's estimates by DEA show that a more realistic figure might be 612,478. Most of the addicts are from seven states. New York alone accounts for over 51 percent of the addicts; the percentage shoots up to over 80 percent with the addition of California, Illinois, New Jersey, Pennsylvania, Florida, and Michigan. About 70 percent of these addicts are between the ages of 18 and 30.

Estimates of extent of abuse of non-narcotic drugs such as marihuana, hallucinogens, stimulants, and depressants are not made from a reporting system such as that described above. Representative surveys of the population, when well designed, can provide reliable figures on the extent, incidence, and prevalence of illegal drug-taking. In 1971-72, a national survey reported the following statistics:

[In percent]

Age:	1971	1972
12 to 13	6	4
14 to 15	10	10
16 to 17	27	29
18 to 21	40	55
22 to 25	38	40
26 to 34	19	20
35 to 49	9	6
50 and over	5	2

It is obvious that the abuse of marihuana has been wider among younger adults. There is much variation in drug use from one college or high school to another, however. Separate studies at schools and colleges show that extent of use of marihuana may vary from 0 percent to 69 percent. Based on projections from these separate studies, it has been estimated by a Federal health agency that 12 to 20 million persons in the United States have tried marihuana at least once.

Lower percents are reported for use of LSD, amphetamines, and barbiturates. Available figures on use of opiates show it to be used by very few students, though observers report an increase in heroin use by high school students.

Surveys of drug use in junior high or elementary schools are too few for generalization, but observers also mention that drug use is increasing among younger children.

Studies among black population indicate considerable use, although accurate figures are not available. Arrest statistics, which are available can only be considered as indicators of the problem rather than as accurate estimates of abuse of opiates.

Cost to Society

Narcotic addicts drain millions of dollars from society. First, the very cost of the drug themselves on the illicit market is exorbitant. The average addict spends approximately $58 each day for a narcotic drug. This means for several days a week, 52 weeks each year, he would require about $21,112—there are no weekends or holidays off from a drug habit. Based on the foregoing estimates, the cost of heroin for addicts in the United States is $36.3 million per day or $13.2 billion per year. Some of the hard narcotic addicts require almost $200 a day instead of $58. The habit produces the craving, and the addict must produce the money. Most of this money feeds directly into the organized criminal structure.

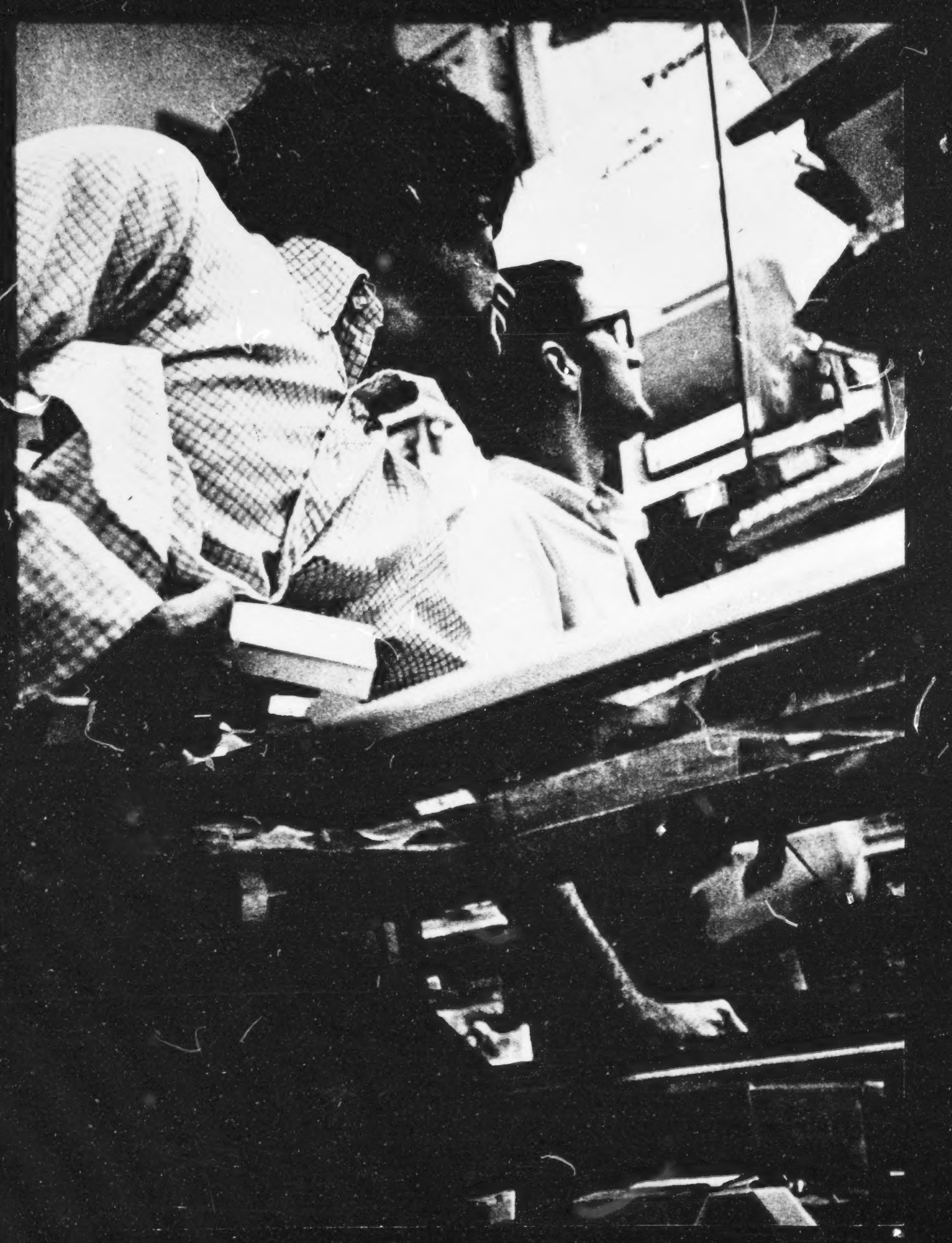
Because most addicts cannot legally obtain the cash to buy their drugs, they turn to crime. Most convert stolen merchandise into cash. It takes about $3-$5 in stolen goods to get $1 cash. So, to support a $58 a day habit, the addict has to steal $200 worth of property a day, or $73,000 a year.

Accepting the fact that some addicts are gainfully employed, some derive their income from selling drugs, while others are engaged in vice reduces considerably the number of addicts actually stealing property to support their habits.

If we assume that 60 percent of the estimated 626,114 heroin addicts steal property to support their habits, over 27 billion dollars worth of property is stolen each year to pay for heroin addiction.

The taxpayer also pays the bill to rehabilitate the addict. A research psychiatrist for one treatment program indicates it cost his State approximately $1,300 a year to rehabilitate just one addict. Doctors in another program estimate six weeks of in-patient treatment followed by aftercare programs totals $3,000. Just assuming the treatment programs were available to all addicts in the country, society would pick up a tab ranging from $828,000,000 to $1,680,000,000.

While these figures are alarming, they do not begin to reflect the total cost of the abuse of narcotics and dangerous drugs.



4

The Drug Abuser

Although much is known about the effects of drugs with abuse potential, the user himself remains an enigma. Slum conditions, easy access to drugs, peddlers, and organized crime have been blamed for the problem. While any of these factors may contribute, no single cause nor single set of conditions clearly leads to drug dependency, for it occurs in all social and economic classes.

The key to the riddle may well lie within the abuser and any one of many sets or conditions. Drug dependency cannot develop without a chemical agent. Yet, while millions are exposed to drugs by reason of medical need, relatively few of these people turn to a life of drugs. It is true that in metropolitan areas, there are invariably found groups of "hard-core" users and a large proportion of the young persons who use drugs in the ghetto areas. Even though drugs may be available on street corners in metropolitan areas, only a small percentage of individuals exposed join the ranks of abusers.

For the most part, hard-core addicts suffer from certain types of emotional instability which may or may not have been apparent prior to initial drug abuse experience. Occasional cases may have a background (often undiagnosed) of psychiatric disorders. Some psychiatrists have said that addicts have an inherent inability to develop meaningful interpersonal relationships. Others have said that addicts are persons who are unwilling to face the responsibility of maturity. Adolescent addicts may have suffered childhood deprivation or overprotectiveness. Or, they simply may not be able to cope with the physical and emotional changes accompanying this period. It is significant that many addicts have their first drug experience in their teens.

The transition from childhood to adulthood is seldom smooth, and many individuals are not emotionally equipped to meet the demands they face. The early and middle teens bring a loosening of family ties, a diminution of parental authority, increasing responsibility and sexual maturing. Beset with anxiety, frustration, fear of failure, inner conflicts, and doubts, the adolescent may find that amphetamines and marihuana promote conversation and sociability; barbiturates relieve anxiety; hallucinogens heighten sensations; and narcotics provide relief and escape. Drug abuse may provide the entree to an "in group" or be a way of affirming independence by defying authority and convention.

In general, drug abusers fall into four main groups. The first group employs drugs for a specific or "situational" purpose. Examples: the student who uses amphetamines to keep awake at exam time; the housewife who uses anti-obesity pills for additional energy to get through household chores; the salesman who uses amphetamines to keep awake while driving all night to an early morning appointment. Such individuals may or may not exhibit psychological dependence.

The second group consists of "spree" users, usually of college or high school age. Drugs are used for "kicks" or just the experience. There may be some degree of psychological dependence, but little or no physical dependence because of the sporadic and mixed pattern of use. Some spree users may only try drugs once or twice and decide there are better things in life. Drug sprees constitute a defiance of convention, an adventurous daring experience, or a means of having fun. Unlike "hard-core" abusers, who often pursue their habits alone or in pairs, spree users usually take drugs in groups or at social functions.

The third is the "hard-core" addict. His activities revolve almost entirely around drug experience and securing supplies. He exhibits strong psychological dependence on the drug, often reinforced by physical dependence when certain drugs are being used. Typically, the hard-core addict began drug abuse on a spree basis. He has been on drugs for some time and presently feels that he cannot function without drug support.

A new type of drug abuser has emerged in the past few years that makes up the fourth group—the "hippies." These drug users tend to believe that the systems of today are either antiquated or wrong, and a new way of life should be found. Drugs are an integral part of the hippie life, and they could be considered the same as the "hard-core" abusers. The major difference is that most hippies do not come from the slum areas, but from middle or upper-middle income families, and their educational level is far above that of the ghetto dweller.

Obviously, there is much overlapping of these groups, and a spree or situational user may deteriorate to the hard-core group, or become enmeshed in the hippie philosophy. The transition occurs when the interaction between drug effects and a personality causes a loss of control over drug use. To the user, the drug becomes a means of solving or avoiding life's problems.

Slum sections of large metropolitan areas still account for the largest number of known heroin abusers. But frustration, immaturity, and the emotional deprivation are not peculiar to depressed neighborhoods, and the misuse of a variety of drugs by middle and upper economic class indi-

viduals is being recognized with increasing frequency. Drug dependence is not discriminating. A drug, an individual an environment which predisposes use, and a personality deficiency are the key factors in its development.

Problems of Abuser Identification

Although drug abuse in its various forms can produce identifiable effects, almost all such manifestations are, at their onset, identical to those produced by conditions having nothing whatever to do with drug abuse.

Many people use legitimate drugs in accordance with physicians' instructions—but without the knowledge of their associates. For example, such disorders as epilepsy, diabetes, or asthma may require maintenance drug therapy that will produce low-level side effects. Or, a person might be drowsy from ingesting a nonprescription product—such as an antihistamine.

A clue to the possibility of drug abuse comes with persistence of symptoms which might otherwise appear "routine." When tablets, capsules, or other forms of drugs are found on a person suspected of being an abuser, they are not necessarily narcotics or any other dangerous drug.

There are no instant tests for identification of most drugs. The only way many drugs can be identified is through a series of complicated laboratory procedures performed by a trained technician. Simple visual inspection cannot be relied upon for drug identification. Many potent drugs which are misused are identical in appearance to relatively harmless drugs—many of which may be readily obtained without a prescription.

Although it is difficult to recognize drug abusers, many potential "hard-core" addicts can be rehabilitated if their involvement in drug abuse is spotted in its early stages . . . when professional help can be brought to bear on the problem in an effective manner.

Common Symptoms of Drug Abuse

Not all drug abuse-related character changes appear detrimental, at least in the initial stages. For example, a usually bored sleepy person may—while using amphetamine—be more alert and thereby improve performance. A nervous, high-strung individual may, on barbiturates, be more cooperative and easier to manage. What must be looked for, consequently, are not simply changes for the worse, but any sudden changes in behavioral expressions which become usual for an individual. The causal factor may be drug abuse.

Signs which may suggest drug abuse include sudden and dramatic changes in discipline and job performance. Drug abusers may also display unusual degrees of activity or inactivity, as well as sudden and irrational flareups involving strong emotion or temper. Significant changes for the worse in personal appearance may be cause for concern, for very often a drug abuser becomes indifferent to his appearance and health habits.

There are other, more specific signs which should arouse suspicions, especially if more than one is exhibited by a single person. Among them are furtive behavior regarding actions and possessions (fear of discovery), sunglasses worn at inappropriate times and places (to hide dilated or constricted pupils), and long-sleeve garments worn constantly, even on hot days (to hide needlemarks). Of course, association with known drug abusers is a sign of potential trouble.

Because of the expense of supporting a drug habit, the abuser may be observed trying to borrow money from a number of individuals. If this fails, he will not be reluctant to steal items easily converted to cash, such as cameras, radios, jewelry, etc. And if his habit is severe enough, forcing him to use drugs while on duty, he may be found, at odd times, in places such as closets, or storage rooms.

In addition to these behavioral clues, which are common to most drug abusers, each form of abuse generally has specific manifestations that help identify those engaged in it. They are as follows:

The Glue Sniffer.—The glue or solvent sniffer usually retains the odor of the substance he is inhaling on his breath and clothes. Irritation of the mucous membranes in the mouth and nose may result in excessive nasal secretions. Redness and watering of the eyes are commonly observed. The user may appear intoxicated or lack muscular control, and may complain of double vision, ringing in the ears, vivid dreams, and even hallucinations. Drowsiness, stupor, and unconsciousness may follow excessive use of the substances.

Discovery of plastic or paper bags and rags or

handkerchiefs containing dried plastic cement is a telltale sign that glue-sniffing is being practiced.

The Depressant Abuser.—The abuser of a depressant drug, such as the barbiturates and certain tranquilizers, exhibits most of the symptoms of alcohol intoxication with one important exception: there is no odor of alcohol on his breath. Persons taking depressants may stagger or stumble. The depressant abuser frequently falls into a deep sleep. In general, the depressant abuser lacks interest in activity, is drowsy, and may appear to be disoriented.

The Stimulant Abuser.—The behavior of the abuser of stimulants, such as amphetamine and related drugs, is characterized by excessive activity. The stimulant abuser is irritable, argumentative, appears extremely nervous, and has difficulty sitting. In some cases, the pupils of his eyes will be dilated even in a brightly lit place.

Amphetamine has a drying effect on the mucous membranes of the mouth and nose with resultant bad breath that is unidentifiable as to specific odor such as onion, garlic, alcohol, etc. Because of the dryness of mouth, the amphetamine abuser licks his lips to keep them moist. This often results in chapped and reddened lips, which, in severe cases, may be cracked and raw.

Other observable effects: dryness of the mucous membrane in the nose, causing the abuser to rub and scratch his nose vigorously and frequently to relieve the itching sensation, incessant talking about any subject at hand, and, often, chain-smoking.

Finally, the person who is abusing stimulant drugs often goes for long periods of time without sleeping or eating and usually cannot resist letting others know about it.

The Narcotic Abuser.—A drug abuser deeply under the influence of narcotics usually appears lethargic, drowsy ("on the nod") or displays symptoms of deep intoxication. Pupils of the eye are often constricted and fail to respond to light.

Some individuals may drink paregoric or cough medicines containing narcotics. The medicinal odor of these preparations is often detectable on the breath.

Other "beginner" narcotic abusers inhale narcotic drugs such as heroin in powder form. Sometimes, traces of this white powder can be seen around the nostrils. Constant inhaling of narcotic drugs makes nostrils red and raw.

For maximal effect, narcotics usually are injected directly into a vein. The most common site of the injection is the inner surface of the arm at the elbow. After repeated injections, scar tissue ("tracks") develops along the course of such veins. Because of the easy identification of these marks, such narcotic abusers usually wear long sleeves at odd times. Females sometimes use makeup to cover marks. Some males get tattooed at injection sites. Associated with the injection of any drugs under unsterile conditions is the hazard of transmitting malaria and other tropical diseases, hepatitis, and blood poisoning.

The presence of equipment ("works" or "outfit") used in injecting narcotics is another way to spot the narcotic abuser. Since anyone injecting drugs must keep his equipment handy, it may be found on his person or hidden nearby in a locker, washroom, or some place where temporary privacy may be found. The characteristic instruments and accessories are a bent spoon or bottle cap, small ball of cotton, syringe or eyedropper, and a hypodermic needle. All are used in the injection process: The spoon or cap holds the narcotic in a little water for heating over a match or lighter, the cotton acts as a filter as the narcotic is drawn through the needle into the syringe or eyedropper.

The small ball of cotton ("satch cotton") is usually kept after use because it retains a small amount of narcotic that can be extracted if the abuser is unable to obtain additional drugs. The bent spoon or bottle cap used to heat the narcotic is easily identifiable because it becomes blackened by the heating process.

The Hallucinogen Abuser—It is highly unlikely that persons who use hallucinogenic drugs (such as LSD) will do so while at work or in other than a recreational time period. Such drugs are usually used in a group situation under special conditions designed to enhance their effect. Persons under the influence of hallucinogens usually sit or recline quietly in a dream or trancelike state. However, the effect of such drugs is not always euphoric. On occasion, users become fearful and experience a degree of terror which may cause them to attempt to escape from the group.

Hallucinogenic drugs are usually taken orally.

They are found as tablets, capsules, or liquids. Users put drops of the liquid in beverages, on sugar cubes, crackers, or even on small paper wads or cloth. It is important to remember that the effects of LSD may recur days—or even months—after the drug has been taken.

The Marihuana Abuser. — While marihuana is pharmacologically a hallucinogen, its widespread use warrants separate discussion.

The user of marihuana ("pot") is unlikely to be recognized unless he is heavily under the influence at that time. In the early stages of the drug effect, when the drug acts as a stimulant, the user may be very animated and appear almost hysterical. Loud and rapid talking with great bursts of laughter are common at this stage. In the later stages of the drug effect, the user may seem in a stupor or sleepy.

Marihuana smokers may also be identified by their possession of such cigarettes, often called "sticks," "reefers," or "joints." A marihuana cigarette is often rolled in a double thickness of brownish or off-white cigarette paper. Smaller than a regular cigarette, with the paper twisted or tucked in on both ends, the marihuana cigarette often contains seeds and stems and is greener in color than regular tobacco.

Another clue to the presence of "reefers" is the way in which they are often smoked. Typically, such smoking occurs in a group situation. But because of the rapid burning and harshness of the marihuana cigarette, it is generally passed rapidly, after one or two puffs, to another person. The smoke is deeply inhaled and held in the lungs as long as possible. The cigarette is often cupped in the palms of both hands when inhaling to save all the smoke possible. An additional clue to marihuana use is its odor. Similar to that of burnt rope, the odor is readily noticeable on the breath and clothing.

5
Drug Abuse Prevention Education

Most states have laws requiring instruction in drug education, but until recently, few good curricula were in use in this country. Now, some schools, by no means all, have tried to provide them. The lack of information on drugs, lack of effective methods of teaching about them, and the lack of training of teachers were found to be serious obstacles to meeting the need.

The Problem

The problem of drug education is both short and long range. In the short range, crash programs to educate pre-teens and teens now in school have met with limited success because of already developed attitudes in these youth. The example of adults, using and abusing legal and prescribed drugs such as tobacco, alcohol, barbiturates, amphetamines, tranquilizers, and over-the-counter remedies of many kinds, has made it difficult to achieve credibility with the teen and pre-teen group.

On the long range, children in kindergarten through the elementary grades need, but are only slowly being provided with, information and experiences that develop attitudes and values which can influence them to reject the easy, counterfeit routes to a satisfying way of living. Much more needs to be done, both in short and long range programs.

Drug Enforcement Administration works with communities, and provides films, materials, and consultative assistance through its Regional Offices. It also conducts special programs for jutsice system/community action, to develop local programs for drug abuse prevention.

The Future

Education of youth is education for our nation's future. In the year 2000, today's kindergartner will be a mature adult. The parent and teacher of today must help our children to depend upon personal resources rather than chemicals for courage, insight, and a sense of purpose. Drug-taking during adolescence short-circuits biological clocks and the process of maturation that tempers young people into responsible adults. If too many of them are damaged and remain in perennial adolescence, our society inevitably will suffer.

Personal control of one's attitudes and values is the measure of maturity, according to many psychologists. Self-discipline, the ability to assess one's own moods, and the postponement of gratification is further evidence of proper development. Young people are not born with these abilities. Their education, training, environment, and circumstances are responsible in large measure for how they mature. Parents, teachers, and communities all share the responsibility for seeing that the young people in their care learn to cope with their personal and social conflicts. The quality of our future depends on how well we accomplish this. Recent statistics which verify the increase in drug abuse as an escape from responsibility are an ominous warning.

Researchers have found that many drug abusers have problems in setting life goals, are apathetic, disinterested, and tend to withdraw from society. Parents and educators must find ways of developing interests, values, attitudes, and life goals for children so that the "drug scene" is not more appealing to them than their daily lives.

Alternatives to Drug Use

There are many things that can be done by groups and individuals, but especially educators and parents, to change the drug user's life style so that constructive activities can replace the drugs which have the central focus.

The time to help these youngsters is before they choose the drug route. They must be offered alternatives to boredom, alternatives to drugs. This requires the development of attitudes and values that oppose drug abuse has an acceptable alternative in their lives. The task is to make young people aware that drugs provide only transitory, counterfeit experiences which can never alter the real world around them. Only constructive activity can do that.

One obvious range of alternatives is related to ways of keeping busy and active. Sports, clubs, community service activities, part-time jobs, hobbies—these are but a few of many ways to keep busy.

Possible Solutions

Our society, at the national, state, community, neighborhood, and family levels, must become more aware of the problem and work toward solutions. What is needed, in general, is more information, more concern for the educative process about drugs, more study and research on the effects of drugs, but most of all, the development of proper attitudes in all our citizens. In the short run, this can be done through the use of mass media, through making parents aware of the problem in numerous ways, and through programming the schools to provide information on the effects and social and personal consequences of drug abuse.

In the long run, our society must become aware of the problem of chemical dependence of all

kinds. Drug abuse is only another aspect of the effects of chemicals in our lives. Chemicals process our food and water, but they also contaminate them and our air and land as well. We have not yet learned to cope with the problems of chemical processing and our very existence depends upon our ability to do so. The old dilemma of whether or not to tell children about drugs no longer exists. The problem has become *what* to tell them and *how* to tell them.

Attitudes and values must be developed toward drugs which categorize them as having potential for great good when properly used and equally great harm when illicitly used. Drugs demand more caution and respect than they receive today. Effective educational programs must lead children from the earliest years, at home and in school, to understand that drugs are not a substitute for nor an escape route from problems or environment.

A sense of proportion is also needed. Although large numbers of young people are said to have tried marihuana, most of them have done so less than three times. They are included in many statistics on drug abusers. This is quite like saying that any young person who has taken a drink of whiskey is an alcoholic. Children will experiment with novelties if they are available. Most of them do not continue. Unfortunately, unless they are made aware of the dangers of drugs, the drug environment and the penalties related to drug use, even experimenters can find themselves in serious trouble.

Possible Educational Approaches

Preaching and exhortation is an old and frequently used approach. This may work when the speaker is highly respected, but may not be generally accepted by today's high school students. Sometimes scare tactics will work if young people can see the real possibility that they can be personally affected (e.g., when a friend dies of an overdose), but generally this approach is ineffective when used with persons who have no idea of the real nature of drug effects, or when it is used in a dishonest or exaggerated way.

Another approach is the use of authorities such as physicians, or even ex-addicts, to discuss the problem. This is useful when there is little peer group pressure to use drugs. High school and college students rate physicians highly, but think law enforcement officials, ministers, and counselors are less convincing. For elementary school children, law enforcement and other institutional authorities rate higher. In the very early grades, the use of police as community members has been found effective in creating an accepting attitude toward the law.

Providing students with status, as when they become experts in drug information and can impart it to someone else, is a useful technique, but obviously must be used only when the information provided is anti-drug abuse.

Traditional courses of study in schools is another widely used approach. This is best done when the drug information is included naturally within a science or health curriculum in a long-range program from kindergarten to grade 12. Attitudes and values must be part of the program from the earliest grades. A key concept is "Only Sick People Need Drugs."

Group discussions, pro and con presentation, and so-called sensitivity sessions can be useful in certain limited circumstances but must be used with extreme caution. In pro and con discussions, even a single hostile response may affect the whole program, for example. Small group discussions with knowledgeable people has the best potential, and large lecture-type assemblies have been found to be of little or no value for young people.

Deglamorization of drug abuse by ridicule, humor, irony, and other illustrative techniques can sometimes be useful. Peer group pressure against drugs can be utilized as a means of keeping some youth from abusing them.

The effects of TV and radio drug advertising on young children creates an atmosphere of acceptance of the idea that "taking something" will solve personal problems as well as treating illness. This "education" by mass media must be continually refuted by parents and the schools. The development of drug "subcultures," so-called in-groups which require drug use for entry or status, must also be combatted by schools and parents. Most young people are turned on to drugs by their friends, not by pushers. The two reasons most often given for using drugs are for "kicks" and to join the "in" crowd. Providing valid alternative activities and programs for every child, and creat-

ing interests before they reach adolescence and must face decisions about drug use is the most effective way of keeping young people out of the "drug scene." Parents, schools, and the community all have responsibilities.

Educational Programs

There are a number of school-developed and commercial programs in use today. Their effectiveness is not known, since most of them have only recently begun. Many school districts are attempting to develop curricula, sometimes required by new state laws. The U.S. Office of Education has initiated a multimillion dollar program for teacher training.

Private organizations such as the Jaycees, Kiwanis, National Association of Retail Druggists, American Pharmaceutical Association, National Coordinating Council for Drug Abuse Education, and many others have programs. The White House, through the Special Action Office for Drug Abuse Prevention, has a ten-point program for coping with the drug abuse problem. The National Clearinghouse for Drug Abuse Information provides general information on request, as well as technical information, to school districts.

Young people must be motivated in their earliest years to enjoy activities and interests. Parents, schools, and communities must take the responsibility of providing the necessary recreational, vocational and avocational facilities and opportunities for every child. Healthy, constructive activities associated with healthy, optimistic, enthusiastic people can go far in turning or keeping youth away from drugs.

The much-publicized idealism of youth can be applied to the real world. Involvement in programs which are of interest or benefit to all of us is one way to keep young people in the main-stream of society. Participation in projects aimed at preservation and restoration of the natural environment; involvement in religion of many kinds; provision for community discussions between young people and knowledgeable adults are all revelant possibilities.

Another range of complementary and somewhat more challenging alternatives to drugs relates to goals and values. An increasing number of youngsters are bored with school. They have no job or career goals. Instead, they flounder in our rapidly changing social and cultural climate. These young people need a strengthened set of values to live by and some specific goals to pursue. Parents and educators must learn to understand the problems of young people in their care and learn to communicate with them. Leadership by knowledgeable adults is a necessity if these young people are going to become "involved" in living.

6

Narcotic Drugs

The narcotic drugs include some of the most valuable medicines known to man as well as some of the most abused. The term narcotic originally referred to opium and the drugs made from opium such as heroin, codeine, and morphine. Opium is obtained from the opium poppy; morphine and codeine are extracted from opium, and heroin is made chemically from morphine. Medical science has subsequently synthesized drugs, called opiates, which have properties similar to heroin, codeine, or morphine. These drugs are also classified as narcotic drugs.

Federal law classifies the coca leaf and a chemical derived from it, cocaine, as narcotics but these drugs are stimulants and medical science does not consider them narcotics. Cocaine is treated in Fact Sheet VIII—Stimulants.

Medicinal Narcotics

Natural and synthetic morphine-like drugs are the most effective pain relievers known. They are among the most valuable drugs available to physicians and are widely used for short-term acute pain resulting from surgery, fractures, burns, etc., as well as to reduce suffering in the later stages of terminal illnesses such as cancer.

These drugs depress the central nervous system to produce a marked reduction in sensitivity to pain, create drowsiness, and reduce physical activity. Other effects can include nausea and vomiting, constipation, itching, flushing, constriction of pupils, and respiratory depression.

Manufacture and distribution of medicinal opiates are stringently controlled by the Federal Government through laws designed to keep these products available only for legitimate medical use. Those who distribute these drugs are registered with Federal authorities and must comply with specific recordkeeping and drug security requirements.

Under Federal law, some preparations containing small amounts of narcotic drugs may be sold without a prescription, for example; cough mixtures containing codeine. Although these preparations are relatively free of addiction potential when used as directed, they have been abused.

Abuse

The abuse of narcotic drugs dates from ancient times. The appeal of morphine-like drugs lies in their ability to reduce sensitivity to both psychological and physical stimuli and to produce a sense of euphoria. They dull fear, tension, and anxiety. Under the influence of morphine-like narcotics, the addict is usually lethargic and indifferent to his environment and personal situation.

Chronic use leads to both physical and psychological dependence. Tolerance develops and ever-increasing doses are required in order to achieve the desired effect. As the need for the drug increases, the addict's activities become increasingly drug-centered.

When the drug supplies are cut off, withdrawal symptoms may develop. Characteristically, they may include nervousness, anxiety, sleeplessness, yawning, running eyes and nose, sweating, enlargement of the pupils, "gooseflesh," muscle twitching, severe aches in back and leg muscles, hot and cold flashes, vomiting, diarrhea, increase in breathing rate, blood pressure, and temperature, and a feeling of desperation and an obsessional desire to secure a "fix." The intensity of withdrawal symptoms varies with the degree of physical dependence and the amount of drug customarily used. Typically, the symptoms begin about eight to 12 hours after the last dose. They increase in intensity and reach a peak in 36 to 72 hours. At this point, the symptoms of withdrawal gradually diminish over the next five to 10 days, but insomnia, nervousness, and muscle aches and pains may last for several weeks.

Addicts live under the perpetual threat of an overdose. This can happen in several ways. An addict may miscalculate the strength of his dose, or the drug may be stronger than it was represented to be at the time the addict bought it. Death from narcotic overdosage is caused by respiratory failure.

Although the possibility of death from an overdose of narcotics is an ever-constant danger to the addict, the harmful effects to the addict are usually indirect. Because addicts do not feel hungry, they often suffer from malnutrition. Because they are preoccupied with the drug taking, addicts usually neglect themselves. They are more apt to contract infections because their nutritional status is poor and because they may inject contaminated drugs intravenously and are likely to be using poor or unsterile injection techniques. This may result in serious or fatal septicemia (blood-poisoning), hepatitis, and abscesses at the site of injection as well as in internal organs.

Heroin

Heroin is a white or brown powder known to the addict as "H," "horse," "caballo," "white stuff," "white lady," "Harry," "joy powder," "doojee," "sugar," "scag," or "smack." It produces an intense euphoria making it the most popularly abused narcotic. Similar to all narcotic drugs, a tolerance develops rapidly and the abuser must ingest increasingly larger quantities to get his "kicks."

Heroin is administered in a variety of ways, including sniffing ("snorting"), smoking, injection under the skin ("joy popping") or into a vein ("mainlining"). For the latter two methods the powder is liquefied before it is administered. The

first emotional reaction is an easing of fears and relief from worry. This is often followed by a state of inactivity bordering on stupor ("on the nod").

Heroin is synthesized from morphine, and weight for weight, is up to 10 times more potent in its pharmacological effects. Pure heroin is "cut" or diluted by the trafficker with substances like milk sugar or quinine, or both.

The drug sold to the addict as heroin usually contains 1 part heroin plus 9 parts or more of other substances.

Morphine

For many years morphine was the drug of choice for the relief of pain. It is called "white stuff," "M," "hard stuff," "morpho," "unkie", and "Miss Emma" by the street addict, and is used by them when heroin is difficult to obtain. Euphoria can be produced with small doses. Tolerance and physical dependence build up rapidly.

Codeine

More commonly abused in the form of cough preparations, codeine is less addictive than morphine or heroin and less potent in terms of inducing euphoria. When withdrawal symptoms occur, they are less severe than with more potent drugs.

Hydromorphone (Dihydromorphinone)

This drug is made from morphine. Although it is almost as potent as heroin, its use does not seem to produce the same thrill as does mainlining heroin.

Oxycodone (Dihydrohydroxycodeinone)

This drug is made from codeine. It is classified as a drug with high addiction potention. Although effective orally, most addicts dissolve tablets in water, filter out the insoluble binders and "mainline" the active drug.

Meperidine

A product of chemcal laboratories rather than poppy fields, this drug was claimed to be without addicting potential when first produced. Experience, however, proved otherwise (as it did with morphine and heroin). Dependence on the drug is slower to develop and less intense than with morphine.

Methadone

Methadone was invented by German chemists in 1941 when the supply of morphine to Germany ran low. It has many properties similar to those of morphine, among which are the ability to relieve pain, and to produce physical and psychological dependence. A major difference between it and morphine and heroin is that when it is taken orally, under medical supervision, it prevents withdrawal symptoms for approximately 24 hours.

7

Marihuana

Marihuana is a greenish tobacco-like material consisting of the leaves, flowers, small stems and seeds of the plant, Cannabis Sativa L. The plant grows throughout the world, especially in Jamaica, Mexico, Africa, India, and the Middle East. It also grows in the United States.

With most drugs the variety of effects experienced and the intensity of the effects is dependent on the dose and the sensitivity of the individual to the drug. This is true also with cannabis preparations. The chemical in the cannabis plant which produces the drug effect is tetrahydrocannabinol (THC). It is not evenly distributed throughout the plant, but varies in decreasing order of concentration as follows: resin, flowers, leaves. Marihuana ("pot," "grass," "Mary Jane") is made primarily from the leaves and has a THC content of 0.2% to 4%. Jamaican ganja, consisting principaly of the flowers and bracts has a THC content of about 4% to 8%. Hashish (charas) the most potent preparation is composed of the drug-rich resinous secretion of the flowers. Generally, the THC content of hashish is 5% to 12%.

Uses of Marihuana

Although known to man for nearly 5,000 years, marihuana is one of the least understood of all natural drugs. Its fibers have been used to manufacture twine, rope, bags, clothing, and paper. The sterilized seeds are used in various feed mixtures, particularly for bird seed.

In the past, marihuana has been used in the treatment of a variety of clinical disorders. Very early in China's history, it was used to relieve pain during surgery. In India, it was used as a medicine, and in the United States, it was used as an analgesic and a poultice for corns. However, marihuana no longer has any acceptable medical use in this country.

Traffic in and use of drugs from the cannabis plant is now restricted by law in most countries, including the United States.

Effects of Marihuana

When smoked, marihuana appears to enter the bloodstream quickly because the onset of symptoms is rapid. It affects the user's mood and thinking. The drug's effects on the emotions and senses vary widely, depending on the amount and strength of the marihuana used. The social setting in which it is taken and the effects anticipated by the user also influence the individual's reaction to the drug.

Usually, the drug's effects commence in about 15 minutes after inhaling the smoke of the cigarette. Its effects can last from two to four hours. At low "social" doses of 1 to 2 cigarettes, individuals who become intoxicated may experience an increased sense of well-being; initial restlessness and hilarity followed by a dreamy, carefree state of relaxation; alteration of sensory perceptions including expansion of space and time; and a more vivid sense of touch, sight, smell, taste, and sound; a feeling of hunger, especially a craving for sweets; and subtle changes in thought formation and expression. To an unknowing observer, an individual in this state of consciousness would not appear noticeably different from his normal state.

At higher, but moderate doses, these same reactions are intensified but the changes in the individual would still be scarcely noticeable to an observer. The individual may experience rapidly changing emotions, changing sensory imagery, dulling of attention, more altered thought formation and expression such as fragmented thought, flight of ideas, impaired immediate memory, disturbed associations, altered sense of self-identity and, to some, a perceived feeling of enhanced insight. Such distortions can produce feelings of panic and anxiety in an individual who has little experience with drugs. The panic and anxiety can cause the individual to fear that he is dying or "losing his mind." This panic reaction is transient and usually disappears as the drug's effects wear off. Low to moderate doses of the drug produce minimal changes in body functions.

At very high doses effects may include distortions of body image, loss of personal identity, fantasies and hallucinations. In addition, toxic psychoses can occur after extremely high doses. This state clears as the drug is eliminated from the body.

A person under the influence of marihuana finds it harder to make decisions that require clear thinking. He finds himself more easily open to other people's suggestions. Tasks which require good reflexes and thinking are affected, and this makes it dangerous to drive while under the influence of the drug.

Marihuana does not cause physical dependence like heroin or other narcotics. This means that the body does not become dependent on the continuing use of the drug. Withdrawal from marihuana does not produce physical sickness as does withdrawal from certain narcotic drugs, though continued use of the drug may cause the build-up of a psychological dependence.

Researchers point out that a person predisposed to the abuse of one drug may be likely to

abuse other, stronger drugs. Also, users of one drug may be exposed to a variety of other drug users and sellers and through this association may be encouraged to experiment with more potent drugs.

In 1966, the active ingredient of marihuana, tetrahydrocannabinol, was synthesized in pure form by an Israeli scientist with support from an American grant. Research is currently being done into the short and long-term effects of the drug. It is anticipated that in the near future scientists will better understand marihuana and its effects on memory, mood, perception, and other physiological and psychological functions. It is also expected that reliable scientific data will become available with regard to chronic toxicity resulting from long-term use of the drug.

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8

Stimulants

These are drugs which stimulate the central nervous system. The most widely known stimulant in this country is caffeine, an ingredient of coffee, tea, cola and other beverages. Since the effects of caffeine are relatively mild, its usage is socially acceptable and not an abuse problem. The synthetic stimulants such as the amphetamines, methylphenidate, phenmetrazine and other closely related drugs are more potent and can be abused. Cocaine, a powerful stimulant obtained from the coca plant, is often abused in combination with other drugs. The stimulants produce excitation, increased activity and an ability to go without sleep for extended periods of time.

Cocaine

Cocaine is a stimulant drug which is obtained from the Erythroxylon coca plant which grows mainly on the western side of South America. The leaves are treated with alkali to release the cocaine. Once used widely as a local anesthetic in eye, nose and throat surgery, it has been replaced largely by newer drugs.

Cocaine is a white or colorless crystalline powder which is abused by inhalation and injection. It can induce euphoria, excitation anxiety, a sense of increased muscular strength, talkativeness, and a reduction in the feeling of fatigue. The pupils become dilated and the heart rate and blood pressure increase. In larger doses, cocaine can produce fever, vomiting, convulsions, hallucinations and paranoid delusions. In cases of overdose, breathing and heart functions may be so depressed that death results.

Because of the intense stimulation received from this drug, most abusers voluntarily seek sedation, sometimes combining depressant drugs with cocaine. (A cocaine-heroin combination is called a "speedball.")

The cocaine abuser may feel a strong psychological dependence on the drug although physical dependence does not develop. When use is stopped, he may feel depressed, and hallucinations may persist.

Amphetamines

The term "amphetamines" describes drugs which have a similar chemical formula. Both amphetamine and methamphetamine are included. These drugs are prescribed for overweight patients to reduce their appetites; in cases of narcolepsy, a disorder characterized by an overwhelming need for sleep; for selected patients with aggressive psychiatric or neurologic disorders; and in some cases of minor chemical depression.

Because the body develops a tolerance to the amphetamines, in time, abusers must increase their dosages to obtain the psychic effects they desire. Tolerance to all the effects does not develop uniformally. Even a "tolerant" abuser can experience high blood pressure, abnormal heart rhythms, loss of appetite, excitability, talkativeness, trembling hands, enlarged pupils, heavy perspiration, and sterotypic compulsive behavior. In serious cases, a drug psychosis resembling paranoid psychosis develops. In addition, violent behavior may follow the use of amphetamines due to unpredictable mood changes and over-reaction to normal stimuli.

Amphetamines for medical purposes are available by prescription under a variety of trade names. They are also manufactured in clandestine laboratories and sold through illicit channels as crystalline powder, tablets and a variety of liquid forms.

As with other dangerous drugs, the slang names frequently are derived from the shapes and colors of capsules and tablets, their effects, or their uses. Examples are:

Amphetamine Sulfate in rose-colored, heart-shaped tablets is known as "peaches," "roses," "hearts," or "bennies."

Amphetamine Sulfate in round, white, double-scored tablets is called "cartwheels," "whites," or "bennies."

Long-Acting Amphetamine Sulfate Capsules found in many colors are known as "coast-to-coast," "L.A. turnabouts," "co-pilots," or "browns."

Amphetamine Sulfate in oval-shaped tablets of various colors is called "footballs" or greenies."

Injectable Amphetamine, in the jargon of the abuser, is called "bombido," "jugs," or "bottles."

Dextroamphetamine Sulfate in orange-colored heart-shaped tablets is known as "hearts," "oranges," or "dexies" (after a trade name).

Methamphetamine HC1 is distributed in a variety of tablets, capsules and in powder called "speed," "meth," "cranks" or "crystal."

Methylphenidate

Chemically, methylphenidate is a distant relative of the amphetamines. It is prescribed for the treatment of mild depression in adults and excessive excitability in children. Its misuse produces approximately the same consequences as does the abuse of the amphetamines.

Phenmetrazine

Like methylphenidate, phenmetrazine is related chemically to the amphetamines, and its abuse produces similar effects. Medically it is used to reduce the appetite.

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Depressants (Sedatives-Hypnotics)

This group includes the barbiturates, the most widely abused among the depressants, glutethimide and meprobamate.

Medical Uses

These drugs depress the central nervous system, and are prescribed in small doses to reduce restlessness, emotional tension and to induce sleep. Some are valuable in the treatment of certain types of epilepsy.

Abuse

Continued and excessive dosages of barbiturates, glutethimide or meprobamate result in slurring of speech, staggering, loss of balance and falling, faulty judgment, quick temper, and a quarrelsome disposition. Overdoses, particularly when taken in conjunction with alcohol, result in unconsciousness and death, unless proper medical treatment is given to the user.

The appearance of drunkenness without an alcoholic breath may indicate excessive use of depressant drugs. However, an unsteady gait and speech problems may also be signs of neurological disorders.

Therapeutic doses cause minimal amounts of psychological dependence whereas excessive doses taken over periods of time result in both physical and psychological dependence. Abrupt withdrawal, particularly from barbiturates, can produce convulsions. Those are exceedingly dangerous and can cause death.

Barbiturates are known to drug abusers as "barbs," "candy," "goofballs," "sleeping pills," or "peanuts." Specific types are often named after their color or shape, for example:

Pentobarbital Sodium in solid yellow capsule form is known by abusers as "yellow jackets" or "nimbies" (after a trade name of this drug).

Secobarbital Sodium in red capsule form is called "reds," "pinks," "red birds," "red devils," and "seggy" (after trade names).

Amobarbital Sodium combined with Secobarbital Sodium in red and blue capsule form is known as "rainbows," "red and blues," or "double trouble."

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Hallucinogens

Hallucinogens are drugs which distort the user's perception of objective reality. They produce illusions involving the various senses and if taken in large doses can produce hallucinations.

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The hallucinogenic drugs are chemicals which have been extracted from plants or have been synthesized in laboratories. Most of the hallucinogens in illicit channels of distribution are processed in clandestine laboratories. Although openly and irresponsibly promoted as a means of expanding consciousness, the hallucinogens have yet to be proved valuable medically. Hence, there are neither standard dosage forms nor markings which make visual identification possible. Illicit labs produce hallucinogens in the form of capsules, tablets, powders or liquids, while peddlers and users will utilize many methods to transport or hide the drugs. For example, LSD has been found in sugar cubes, candy, paper, aspirin, jewelry, liquor, cloth, and even on the back of postage stamps.

Drug Effects

The effects experienced after taking hallucinogens are not solely related to the drug. They are modified by the mood, mental attitude and environment of the user. Usually hallucinogens distort or intensify the user's sense perception and lessen his ability to discriminate between fact and fantasy. A user may speak of "seeing" sounds and "hearing" colors. His judgments of direction, distance, and objectively are generally out of proportion. His pupils are dilated, and his eyes are extremely sensitive to light. Restlessness and sleeplessness are common until the drug wears off. Mental effects of the drugs are unpredictable, and equally unpredictable each time taken, ranging from illusions, exhilaration, withdrawal from reality, and violent movement or self-destruction, to sheer panic. This unpredictability of the effects of hallucinogenic drugs is the greatest danger to users. As with stimulants and depressants, the user of hallucinogens may develop a psychological dependence upon these drugs. However, unlike depressants, hallucinogens have not been shown to produce a physical dependence.

LSD-25 (Lysergic Acid Diethylamide)

Known to the "hippie" cult as "acid," this drug is derived from the ergot fungus, a disease which affects rye and wheat grain. A dose of 50 to 200 micrograms (a quantity no larger than the point of a pin) will take the user on a "trip" for approximately eight to 16 hours.

Physical reactions may include dilated pupils, lowered temperature, nausea, "goose bumps," profuse perspiration, increased blood sugar, and rapid heart beat. During the first hour after ingestion, the user may experience visual changes followed by extreme changes in mood. In the hallucinatory state, the user may suffer loss of depth and time perception accompanied by distortions with respect to size of objects, movements, color, spatial arrangement, sound, touch, and his own "body image." During this period, the user's ability to perceive objects through the senses, to make sensible judgments, and to see common dangers is lessened and distorted, hence making him susceptible to personal injury. He may also injure others in the event he decides to drive a car.

After the "trip," the user may suffer acute anxiety or depression for a variable period of time. Recurrences of hallucinations have been reported days, or months, after the last dose. Psychoses, both short and long-range, have followed the use of LSD for some. It is not yet known whether the drug causes the illness or merely precipitates it.

Regular use of LSD does not lead to physical dependence, but if the experience is pleasant to the user, a certain psychological dependence may develop. It is possible, too, that the regular user may build up a tolerance to the drug—wherein regular doses produce lesser effects or no effect at all, thus necessitating an increase in the amount consumed.

Together with other hallucinogens, LSD is considered an investigational drug and its action on the body and nervous system is not yet understood. It has become the subject of considerable scientific study. Recently, independent experiments with animals show that LSD may cause central nervous system malfunctions. Research is currently being conducted into possible chromosomal effects from use of LSD.

Experimentation is being conducted by approved investigators on alcoholics and the mentally disturbed to determine if the drug produces any therapeutic benefits.

Since the Government has taken steps to curb the illegal traffic in lysergic acid and lysergic acid diethylamide, drug abusers are using LSD of untested purity and strength. Use of bootleg LSD peddled to the abuser in various dosage forms of uncertain quantity and purity may add another

hazard to the use of the drug. The only legitimate supply of LSD for scientific research is available through the National Institute of Mental Health, Bethesda, Md.

Mescaline (Peyote)

Mescaline, which is derived from the buttons of the peyote cactus plant, has been used for centuries by various Indian tribes of Central America and the southwestern United States. The Native American Church, which uses peyote in religious ceremonies, has been exempt from certain provisions of the Federal law. Generally ground into a powder, peyote is taken orally. A dose of 350 to 500 milligrams of mescaline produces illusions and hallucinations for five to 12 hours. Like LSD, mescaline is not likely to produce physical dependence but may cause psychological dependence.

Psilocybin and Psilocyn

Also derived from plants, psilocybin and psilocyn are obtained from certain mushrooms generally grown in Mexico. Like mescaline, they have been used in Indian rites for centuries. Their effects are similar to those of mescaline, except that a smaller dose, four to eight milligrams, is ample. The experience lasts for approximately six hours. Psilocybin and psilocyn do not produce physical dependence, although users have been known to develop a tolerance to them.

DMT

DMT is a short-acting hallucinogen found in the seeds of certain plants native to the West Indies and parts of South America. The powdered seeds have been used for centuries as a snuff—called "cohoba"—in religious ceremonies to produce a state of mind which the Haitian natives claimed enabled them to communicate with their gods. It is also produced synthetically by clandestine chemists. DMT is not taken orally, but its vapor is inhaled from the smoke given off by burning the ground seeds or powder mixed with tobacco, parsley leaves, or even marihuana. It can also be injected. The effects of a single dose, 60 to 150 milligrams, last from 45 to 60 minutes and will produce mainly hallucinations. It may cause psychological but not physical dependence.

DET (Diethyltryptamine)

DET is chemically related to DMT but has not yet been found in plant life. However, it can be produced in a laboratory. Injecting a dose of 50 to 60 milligrams causes visual distortions, dizziness, and a vague sense of time. The experience may last from two to three hours. DET is usually taken by smoking it in a mixture of tobacco, tea, parsley, or marihuana.

DOM

Known popularly as "STP," this drug appeared on the psychedelic scene in the early spring of 1967. Articles in the underground newspaper promoted its use, claiming STP to be stronger than LSD. The compound was identified by FDA chemists to be 4-methy1-2,5-dimethoxyamphetamine, or DOM. Little is known about the therapeutic, pharmacological, or psychological effects. However, it is known that low doses, two to three milligrams produce effects similar to those produced by amphetamine; moderate doses, five milligrams, produce effects lasting 6 to 8 hours which are similar to those produced by mescaline and large doses can produce convulsions. One of the approved investigators of the drug states that "STP" is almost 200 times more powerful than mescaline, but only one-tenth as potent as LSD. "STP" is not found in nature, but is synthesized in the laboratory and has appeared in illegal channels in tablet form.

PCP (Phencyclidine)

Phencyclidine, a hallucinogen in humans, is legitimately manufactured as a veterinary anesthetic. It is produced also in clandestine laboratories and sold as "PCP," "Peace Pill," "Hog," and "Angel Dust." The "trip" which it produces often includes feelings of weightlessness, diminishing body size, loss of comprehension of the immediate environment, and feelings of dying or of being dead. It also intensifies overt or latent psychotic tendencies. A PCP "trip" can be very alarming especially if it is unexpected. This is happening frequently because PCP is being sold as mescaline, LSD, THC, or mixed with other drugs. Such "trips" are especially hard to treat due to ignorance of the drug's identity.

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Audio-Visual Aids

A number of films and slide sets on drugs and narcotics are available on a loan basis, without cost, for public use from the new Drug Enforcement Administration's Regional Offices. (See inside back cover of Fact Sheets for addresses.) Since demand for these materials is heavy, it is recommended that requests be made 30 days in advance. In addition, the films may be purchased or rented from theaddresses listed below. Permission to use any of the films on TV or in a movie theater must be obtained from the producers. The prices shown after each film listed are subject to change. These films vary greatly in emphasis and impact. It is strongly urged that any film be previewed before showing to determine its suitability for the intended audience and that provisions are made for a discussion of drugs led by a knowledgeable person or persons.

Drug Abuse Education Slide Resource Kit

This is a series of slides for use by qualified drug abuse education and information speakers to supplement their own presentation. There are eight sections of slides; each section is color-coded to match accompanying cards with captions designed to assist in adapting the slides into the speaker's presentation. Some sections are designed only for special audiences, while other sections can be used for general audiences. The color coded sections include:

A. History of Drug Abuse (18 slides, $6)
B. Drug Abusers' Propaganda (15 slides, $5.50)
C. Drugs of Abuse (33 slides, $10)
D. Drugs and Your Body (12 slides, $5.50)
F. Rehabilitation and Treatment Centers (22 slides, $7)
G. Drug Abuse Education Material (20 slides, $6)
H. Drug Abuse Education Programs and Councils (15 slides, $5.50)

Available from the National Audiovisual Center (GSA), Washington, D.C. There is no copyright on any of the slides or cards and the material may be reproduced in whole or in part without permission by any person or parties. Purchase price: $55 for the entire kit.

Films

A Day in the Death of Donnie B.

Described are the events in one day in the life of a black heroin addict. He is a teenager who spends his time looking for the next "fix." A song on the sound track was distributed commercially. The film is intended for inner-city audiences, professionals, and selected adults and late teens. 16mm, sound, black and white. Running time: 14 minutes, Available National Audiovisual Center (GSA) Washington, D.C., 20409. Purchase price: $27.

Beyond LSD

This film covers the communication gap between two generations: teenagers and young adults on the one hand, and those over thirty—"the Establishment"—on the other. In this film, a group of parents seek help in order to understand why alienation between parents and children may lead to drug use. It is intended to stimulate thought and motivate discussions among parents, students, and teachers. 16mm, sound, color. Running time: 25 minutes. Available: Baily Film Associates, 11559 Santa Monica Boulevard, Los Angeles, Calif. 90025. Purchase price: $300. Write for rental rates.

LSD-25

This presentation provides a rational view of the use of LSD and insight into the varied effects on the user of the hallucinogenic drugs. It is effective in reaching the intended audience of high school and college level students. 16mm, sound, color. Running time: 26 minutes. Available: Professional Arts, Inc. P.O. Box 8484, Universal City, Calif. Purchase price: $275

LSD: Insight or Insanity

The dangers of unsupervised use of LSD are documented, and what is known about its physiological and psychological effects are explained in this film. It counters some of the erroneous claims made in promoting the use of the drug and discusses possible chromosome damage which may result from the use of LSD. The film is intended for high school and college level audiences. 16mm, sound, color, Running time: 29 minutes. Available: Baily Film Associates, 2211 Michigan Ave., Santa Monica, Calif. Write for purchase price.

The Riddle

Stripping drug abuse of any vestiges of glamor, the camera follows actual glue sniffers, cough medicine drinkers, and heroin addicts into the alleys, tenements and physician's offices where their candid comments and bewildered responses clearly show the hopelessness of their lives. By contrast, an account of a youth who resists the drug abuse crowd to land a job strikes a hopeful note. The film is intended for junior and senior high school audiences. 16mm, sound, black and white. Running time: 20 minutes. Write to Public Affairs, Office of Economic Opportunity, 1200 19th St. N.W., Washington, for details on purchase.

Community As A Doctor

This 30-minute film shows how a community must act as a cohesive unit in order to combat the spread of drug abuse. The film answers many of the questions which a community may have about "getting it all together." It emphasises that all of the community must be a part of the effort. Available: Dick Ham Production, 459 Hamilton Avenue, Palo Alto, California. Purchase Price: $349, Running time: 30 minutes, 16mm, sound, color.

11:59: Last Minute to Choose

Filmed in the emergency room of a large metropolitan hospital, this film explains, through actual experiences, the pitfalls of the misuse of drugs

and what led the respective individual to make his decision. The intended audience is senior high school, college, adult and those professionals in the criminal/justice system. Available: Holt, Rinehart and Winston, Inc., Media Dept., 383 Madison Avenue, New York, New York. Purchase price: $375. Running time: 27 minutes, color, 16mm, sound.

The Perfect Drug Film

This film explores the question "Does our society need a perfect drug?" It has an excellent section on drug abuse history. It is designed for use by students in the 12-18 year-old age group. Available: CCM Films, Inc. 34 MacQuesten Pkwy. South, Mount Vernon, New York. Purchase Price: $350. Running time: 28 minutes, 16mm, color, sound.

What Did You Take

Originally produced to show medical personnel emergency treatment for overdoses of the various drug classification, this film can be used in educating other professionals. This film should not be shown without an accompanying lecture. Available: Knightsbridge Production, Inc., Suite 3D, 155 East 38th St., New York, New York. Running time: 30 minutes. Purchase price: $315. color, 16mm, sound.

Driving and Drugs

The purpose of this film is to make students aware of ways in which drugs affect driving. It provides the facts for young people to make their own decisions. The film is intended for high school, college, and adult audiences. 16mm, sound, color. Running time: 14 minutes, 30 seconds. Cleared for television. Available on free short-term loan basis from Modern Talking Pictures, Inc. (offices in every major city), Chevrolet Motor Division Zone and Regional Offices, and General Motors Film Library, General Motors Building, Detroit, Michigan, 48202. For purchase information, write to: Audio Visual Department, General Motors Photographic, General Motors Building, Detroit, Michigan, 48202.

Drug Abuse: Everybody's Hang-up

A documentary-like look at the drug abuse scene, this film attempts to heighten awareness of and concern with the problem. The film does not attempt to provide answers to this difficult problem. It does, however, offer suggestions that may help parents keep their children off the chemical road to nowhere. The film is intended for school and college teachers and administrators, community groups, and parents. 16mm, sound, color, Running time 14 minutes, Available: National Education Association, 1201 16th St., N.W. Washington, D.C. Purchase price is $90.

Drugs and the Nervous System (revised)

The film explains how drugs affect many different parts of the body by working on the central nervous system. The major portion of the film explains the serious disruption of the nervous system caused by drugs, narcotics and other substances taken for "kicks." Substances covered are airplane glue, stimulants (amphetamines), marihuana, and LSD. The film is designed for junior high and senior high and college age audiences. 16 mm, sound, color. Running time: 18 minutes. Available: Churchill Films, 662 North Robertson Blvd. Los Angeles, Calif. 90069. Purchase price: $180. Films are now also available in French and Spanish. Baily Films, Inc. 6509 De-Longpre Avenue, Hollywood, Calif. Purchase price: $300.

Marihuana

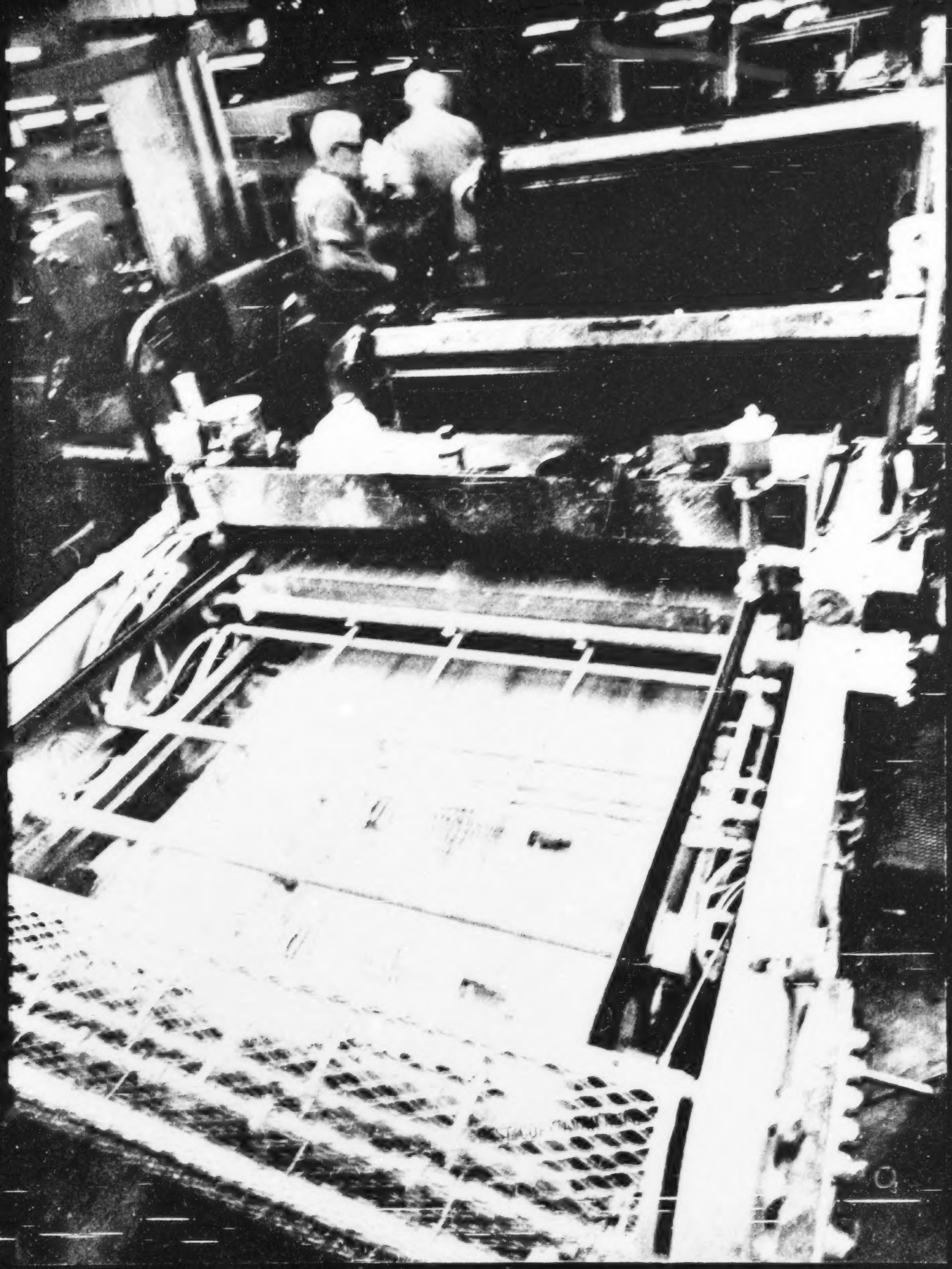
Sonny Bono narrates this film. He relates to the teenagers and provokes them to think for themselves. The film examines simply the facts about physical dangers, emotional dependency, and legal aspects of marihuana usage. It is intended for junior and senior high school and college students, as well as concerned adults. 16mm, sound, color. Running time: 34 minutes. Available: Baily Film Associates, 11559 Santa Monica Blvd. Los Angeles, Calif. Purchase Price: $350.

Speedscene: the Problem of Amphetamine Abuse

Graphic evidence against the use of amphetamines in any form for other than medical reasons is offered in this film. It delves into the daily life of "speed" users and the effects it has on them. It also has some dramatic footage on how methamphetamine affects a colony of white mice. It is intended for junior and senior high school, college and adult audiences. 16mm, sound, color. Running time: 17 minutes. Available Baily Film Associates, 11559 Santa Monica Blvd. Los Angeles, Calif. Purchase price $210.

HOOKED

Young people (ages 18-25) describe their experiences with drug addiction in this film. The descriptions are uninhibted and sometimes shocking. The young people speak with candor about what impelled them to use drugs, how drug abuse affected their relationships with others, and the disgust with which they now regard their drug experiences. The film is intended for junior and senior high school audiences. 16mm, sound, black and white. Running time: 20 minutes, Available: Churchill Films, 662 North Robertson Blvd. Los Angeles, Calif. Purchase price is $125.



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Publications

Drug Enforcement Administration

A wide array of publications covering many topics is prepared for those within the criminal justice system by the Drug Enforcement Administration. These are books, pamphlets, flyers and posters designed to reach a variety of audiences. School children, teenagers, athletes, parents, educators, law enforcement officers, concerned citizens--each group can find material tailored to its needs.

Single copies of these publications may be obtained by writing the Drug Enforcement Administration, 1405 I Street, NW, Washington, D.C. 20537.

Up to fifty copies of certain publications may be obtained from DEA for use by those within the criminal justice system.

National Clearinghouse for Drug Abuse Information

The National Clearinghouse for Drug Abuse Information is operated by the National Institute of Mental Health on behalf of the Special Action Office for Drug Abuse Prevention and the Federal agencies engaged in drug abuse education programs. These Federal agencies are the Department of Justice, Department of Health, Education and Welfare, Office of Economic Opportunity, and the Department of Defense.

The Clearinghouse is the focal point for Federal information on drug abuse. The Clearinghouse distributes publications and refers specialized and technical inquiries to Federal, State, local and private information resources.

Inquiries should be directed to the National Clearinghouse for Drug Abuse Information, 5600 Fishers Lane, Rockville, Maryland 20852.

Government Printing Office

Copies of DEA publications may be purchased (where indicated and at the prices shown) from the Superintendent of Documents, Government Printing Office (GPO), Washington, D.C. 20402. There is a 25% discount on any individual order of 100 copies or more. The negatives of publications are also for sale at GPO for those parties who wish to have them reproduced locally.

Katy's Coloring Book About Drugs and Health

This coloring book is geared to children ranging in age from pre-school to eight years. A guide for parents and teachers is included in the text. No mention of narcotics and dangerous drugs is made. The major theme is "Only Sick People Need Drugs." 18 pages $.35 G.P.O.

Fact Sheets

Designed for general use, this basic publication provides an overview of the problem, laws relating to it, and other pertinent information. The booklet is printed in three separate editions—English, Spanish, and French. 72 pages $.60 G.P.O.

A Community Program Guide: Drug Abuse Prevention

The pamphlet is geared to local organizations, aiding them to plan a coordinated drug information program. The topics discussed begin at the planning stage and follow through to a program of action. 20 pages $.20 G.P.O.

Wanted: Dead or Alive

This is a full color poster describing marihuana from the field to the cigarette. Intended for eradication programs, it is also effective for law enforcement programs in identifying marihuana. 21" x 16". $.20 GPO.

Drugs of Abuse

The general public will find this sixteen page, full color booklet most helpful. It identifies the drug controlled by DEA, and it describes the ways in which they are abused.

Terms and Symptoms of Drug Abuse

Taken from *Drugs of Abuse*, this chart depicts the various adverse symptoms which come from the abuse of drugs. Two sizes: 10" x 16" and 30" x 40" $.35 G.P.O.

Marihuana, '72

Former BNDD Director Ingersoll's testimony before the National Commission on Marihuana and Drug Abuse is contained in this pamphlet reprinted for general use. It presents BNDD's view of the problem, based on the latest research on the effects of cannabis use. 47 pages.

Pro-Drug Dialectic Communications and the Marihuana Red Herring

This paper was originally submitted to the Rutgers University Drug Symposium by Dr. Henry Brill, Director Pilgrim State Hospital. This article is a must for those who talk to young people about drug abuse for it analyzes the often-heard arguments in favor of legalization of marihuana, and other non-medical use of drugs. 20 pages

Drug Taking in Youth

This book paints a picture, based on reliable facts, of the current drug phenomenon—mainly its social and psychological aspects. The material will be of particular interest to teachers, parents, group workers, or any others for whom young

people are a responsibility. 48 pages $.40 G.P.O.

The Coach: Drug, Ergogenic Aids and the Athletes

This pamphlet, sponsored by the NCAA, is aimed at coaches. It explains the drugs which athletes may abuse and clarifies misconceptions concerning their use. 16 pages. Additional copies may be obtained from the NCAA, 1221 Baltimore Street, Kansas City, Missouri, 64105 $.25

Drugs and the Athlete

The NCAA distributes this leaflet which tells the student athlete of the dangers of attempting to improve athletic performance with drugs. Coaches, trainers, and parents would also benefit from this information.

Available from NCAA (see above)

Are You Just Watching . . .

A single page flyer directed to the concerned citizen. It alerts the community to drug related crimes.

Free in quantity

LSD 25: A Factual Account

As a layman's guide to LSD, this booklet provides the public factual information about the pharmacology, physiology, psychology, and sociology of LSD. Although it is not a scientific treatise certain technical terms have been retained because of their specific meanings. A glossary is included for those who are unfamiliar with these terms. 44 pages $.30 G.P.O.

The Non-Medical Use of Dangerous Drugs in the United States: A Comprehensive View

This paper is suitable for those who are interested in a scientific review and discussion of some of the methodological and epidemiological aspects of a compilation of studies, surveys, and polls of the nonmedical use of dangerous drugs and other "exotic" substances in the United States. 9 pages.

Community Drug Abuse Prevention Series

Law Enforcement
People Involvement
Concerned Businessmen's Committee
Checklist
Community Drug Abuse Prevention Week

These pamphlets give tips to a community on how to get a local program started. Emphasis is placed on involvement of the entire population; there is a role for every kind of group—clergy, youth groups, PTA, unions, lawyers—for any interested persons and organizations.

Public Speaking on Drug Abuse Prevention: A Handbook for the Law Enforcement Officer

The purpose of this handbook is to provide some partially prepared material for the use of law enforcement officers, and to gather together information on some of the most frequently asked questions on the subject of drugs. 40 pages $.30 G.P.O.

Spanish Publications

Marihuana
Drogas
Heroina
Delireantes
LSD
Cocaina
Anfetaminas
Barbiturates

These pamphlets have been adapted from publications of the New York State Narcotic Addiction Commission. Translated into Spanish, they will help to educate those members of the Spanish speaking community who are not fluent in English. Using a question-answer technique the pamphlets identify the above listed drugs and explain the problems associated with their use.

Citizen Support for Law Enforcement

This pamphlet is available to law enforcement agencies and established citizens groups (Chamber of Commerce, etc.). It describes various ways in which local citizens' groups can assist Law Enforcement Agencies through combined efforts to combat drug abuse. 48 pages

A Federal Source Book: Most Frequently Asked Questions About Drugs

Designed for general use as a popular reference, this publication presents the latest scientific answers to some of the questions most frequently asked about drug abuse. The answers are based on the latest research findings of the National Institute of Mental Health and are presented in accord with the policies and programs of HEW, OEO, and the Departments of Justice, Labor, and Defense. 30 pages $.25 GPO

National Institute of Mental Health Pamphlet Series

Drug Abuse: Some Questions and Answers $.10 GPO

LSD: Some Questions and Answers $.10 GPO

Narcotics: Some Questions and Answers $.10 GPO

Marihuana: Some Questions and Answers $.10 GPO

International Drug Abuse Manual

The purpose of this guide is to provide some basic information on drug abuse to law enforcement officers in order to assist them in their task of curbing illicit traffic in drugs. This manual is printed in English, French, and Spanish. 72 pages. Available only from Smith, Kline and French Laboratories, 1500 Spring Garden Street, Philadelphia, Pa. 19101.

Methadone Maintenance

This paper was prepared by Nathan B. Eddy, MD and expresses the personal judgment of the author. Professionals involved in treatment programs will find this interesting. 24 pages.

Marihuana and Health

The Second Annual Report to Congress from the Secretary of HEW included not only the effects of the drug on the individuals physical and psychological health but also the effect of cannabis use on the society. Available to researchers and education professionals, it would be of interest only to those who have a knowledge of the law and legal terms. 61 pages $.20 GPO.

Code of Federal Regulations—Food and Drugs (21)

The Code of Federal Regulations is a codification of the general and permanent rules published in the Federal Register applying to the Drug Enforcement Administration. This Code also contains schedules of controlled substances. Available only to registrants and concerned organization.

Glossary of Terms

This pamphlet gives street jargon for various drugs and terms associated with drugs. Those who work with youth or need to understand street language will benefit most from this pamphlet.

Marihuana: A Signal of Misunderstanding

This report by the National Commission on Marihuana and Drug Abuse to the President and Congress is an effort to demythologize the controversy surrounding marihuana. $1.00 184 pages. Available only from GPO.

Guidelines for Drug Abuse Prevention Education

This booklet was originally prepared for the workshop for educators conducted by the Concerned Business Committee of Pheonix, Arizona. Now revised for general teacher use, it includes sample courses of study, and an appendix which lists many helpful reference and visual aids. 276 pages. For sale only at GPO.

Wild Hemp

Marihuana is pictorially represented and described in this Department of Agriculture flyer designed for use by law enforcement and state regulatory agency personnel. $.10 GPO.

Stimulants: Some Questions and Answers $.10 GPO

Depressants: Some Questions and Answers $.10 GPO

Alcohol: Some Questions and Answers $.10 GPO

Cigarette Smoking: Some Questions and Answers $.10 GPO

Volatile Substances: Some Questions and Answers. $.10 GPO

The above listed pamphlets are designed to give factual information to the general public. A question and answer format is used to clarify those areas which most people wonder about. Some of the subjects covered are the identification of the substance, effects of its use, extent of its abuse, and a sampling of federal research and other activities that are now under way.

Public Law 91-513

This is a copy of the Drug Abuse Prevention and Control Act of 1970. It contains two titles: Title I Rehabilitation Programs Relating to Drug Abuse; and Title II—Control Enforcement. Because of its specialized language, it would be of interest only to those who have a knowledge of the law and legal terms. 61 pages. $.20 GPO.

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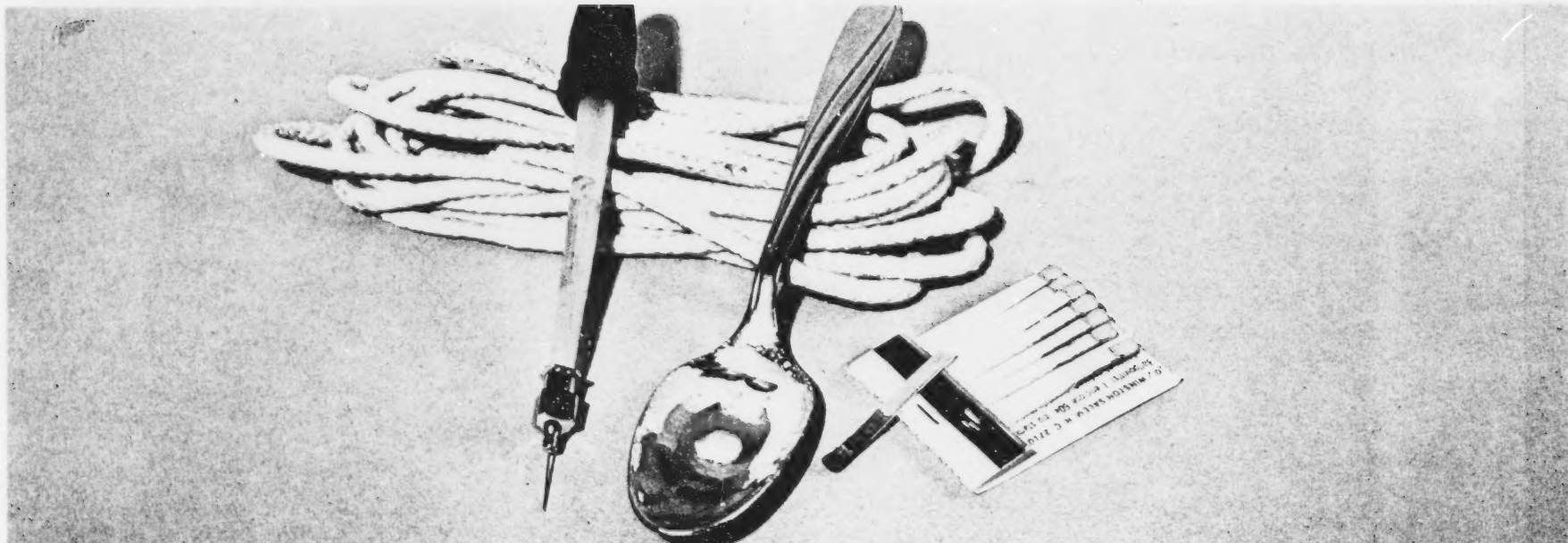
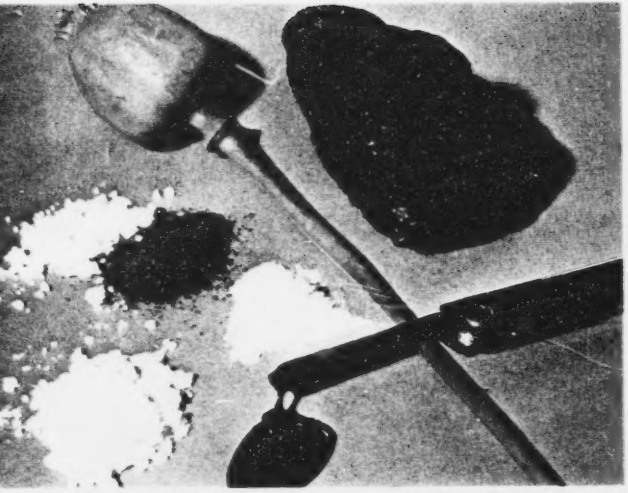
Drug Identification



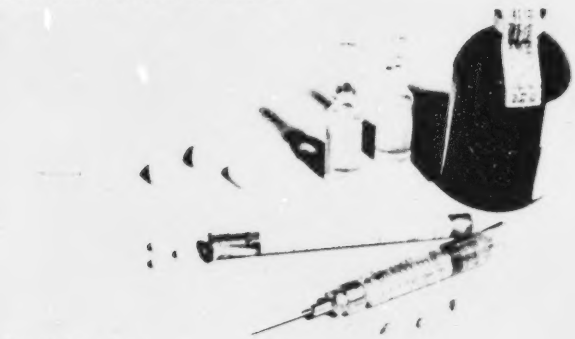


ıium poppy and Derivatives - crude opium, codeine, Heroin & Morphine

Forms of Heroin

a leaves & Illicit forms of Cocaine

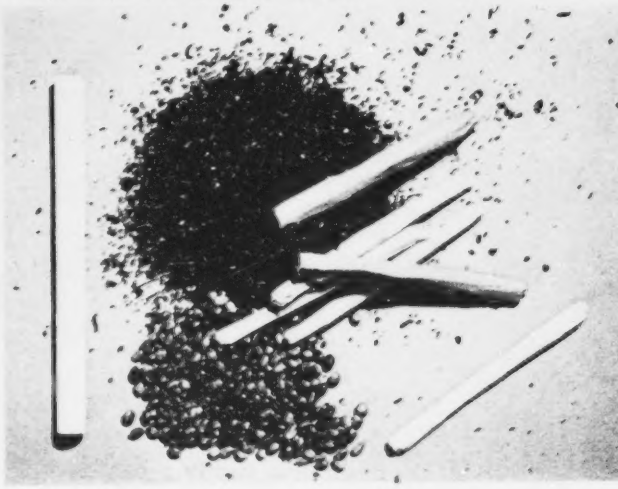
Hashish



rms of Morphine

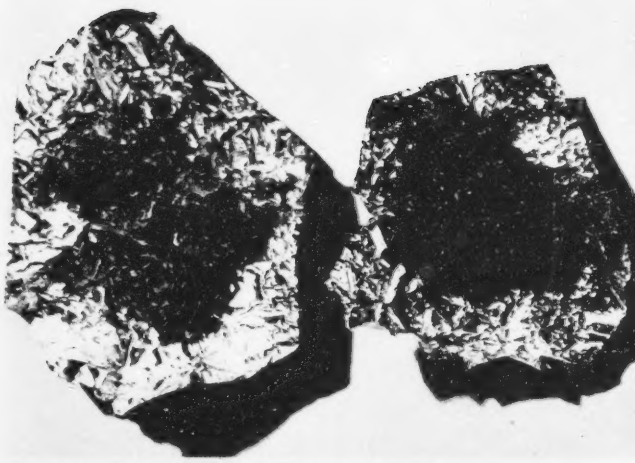
Exempt Narcotics - cough syrup with codeine

o bricks of Marihuana

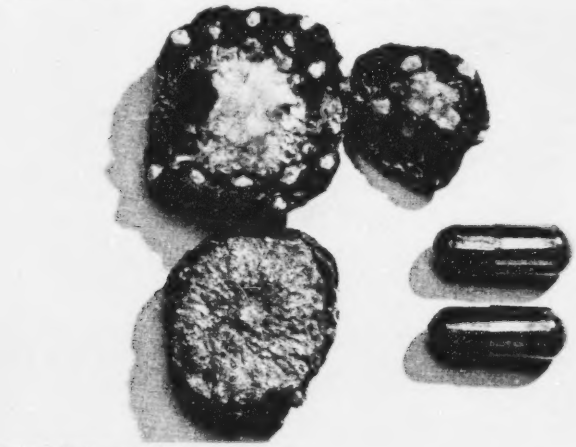


Manicured Marihuana, cigarettes and seeds

Illegitimate forms of Lysergic Acid Diethylamide (LSD)

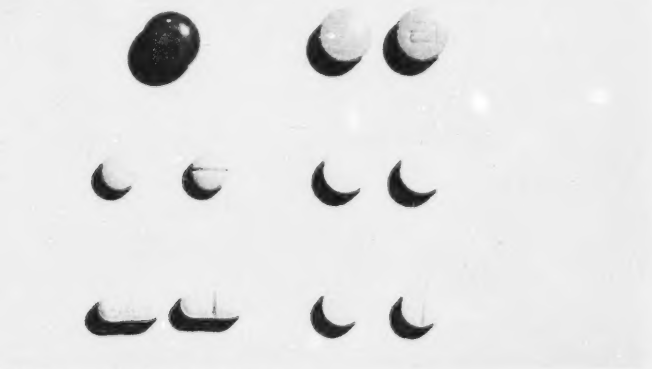


Dimethyltryptamine (DMT) on Tobacco and Parsley leaves

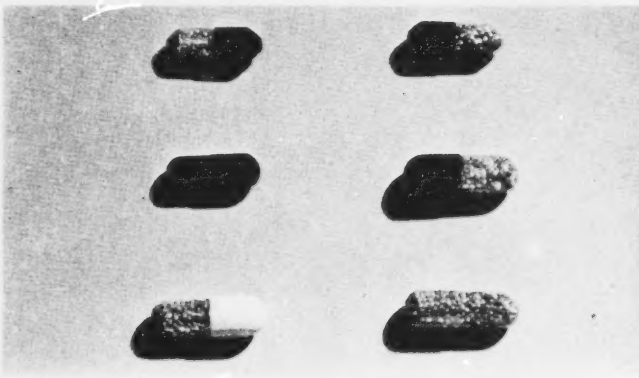


Peyote Buttons and ground Peyote

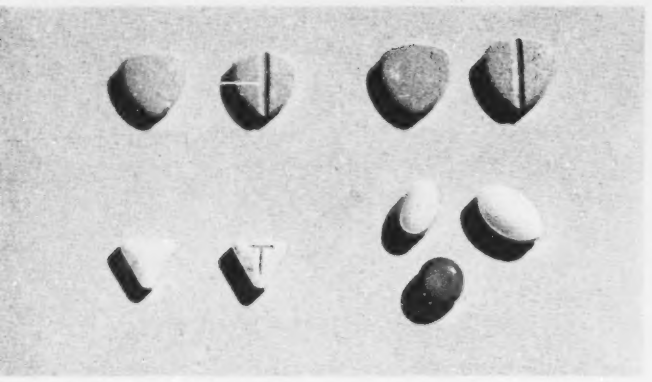
Psilocybe Mushrooms



Miscellaneous Barbiturate Tablets

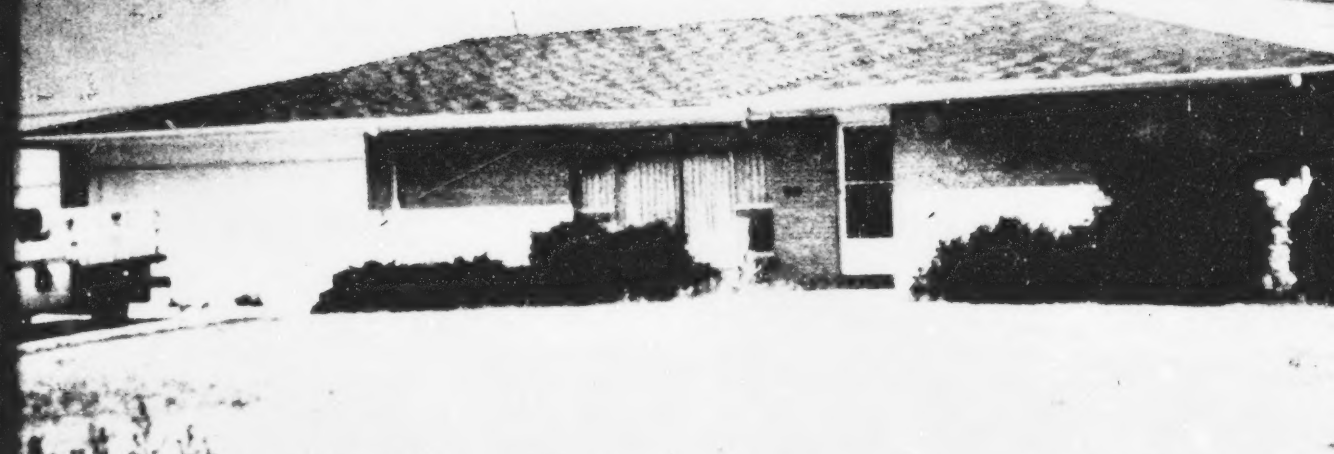


Amphetamines



Stimulants

Depressants



ILLICIT LAB Seeing how dry the grass was, the landlord stopped to tell his tenant that he must water the lawn. When he knocked at the door he got no answer but smelled a pungent odor which he thought to be a dead body. Upon investigation, the Denver Police dis covered the house contained an illicit STP and LSD laboratory. The entire water supply had been diverted to the laboratory.

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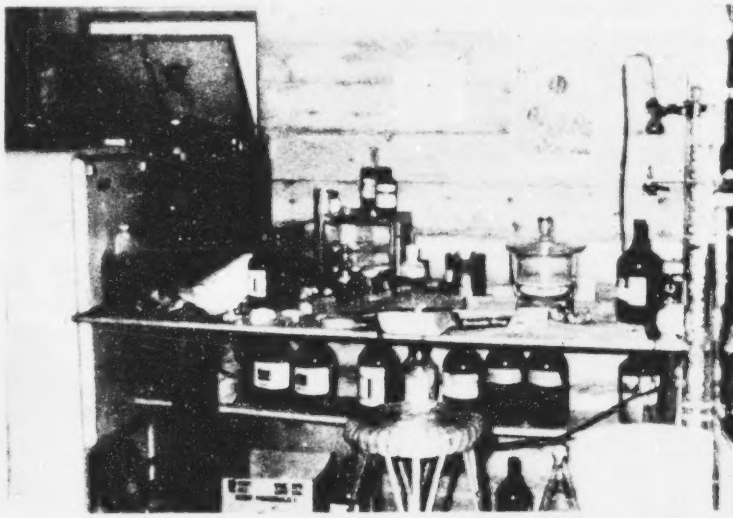

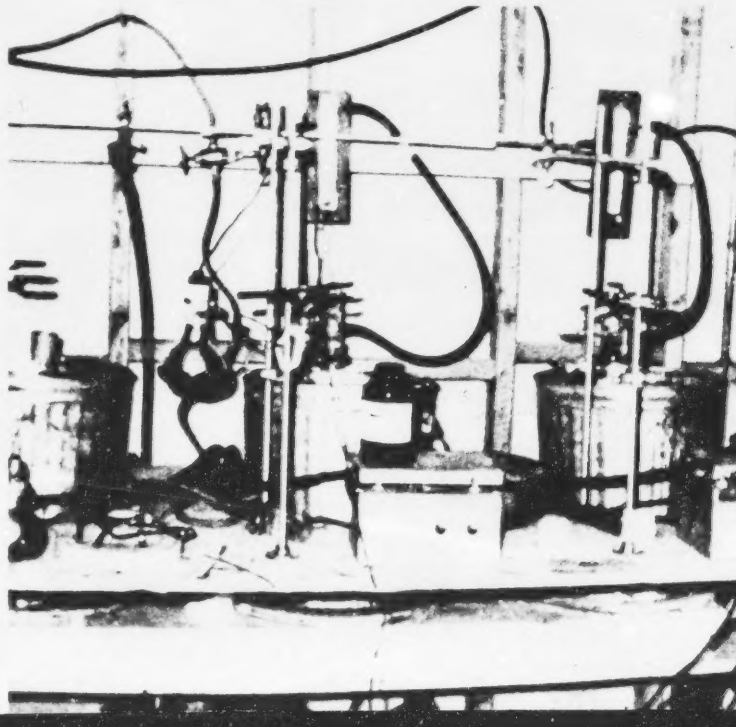

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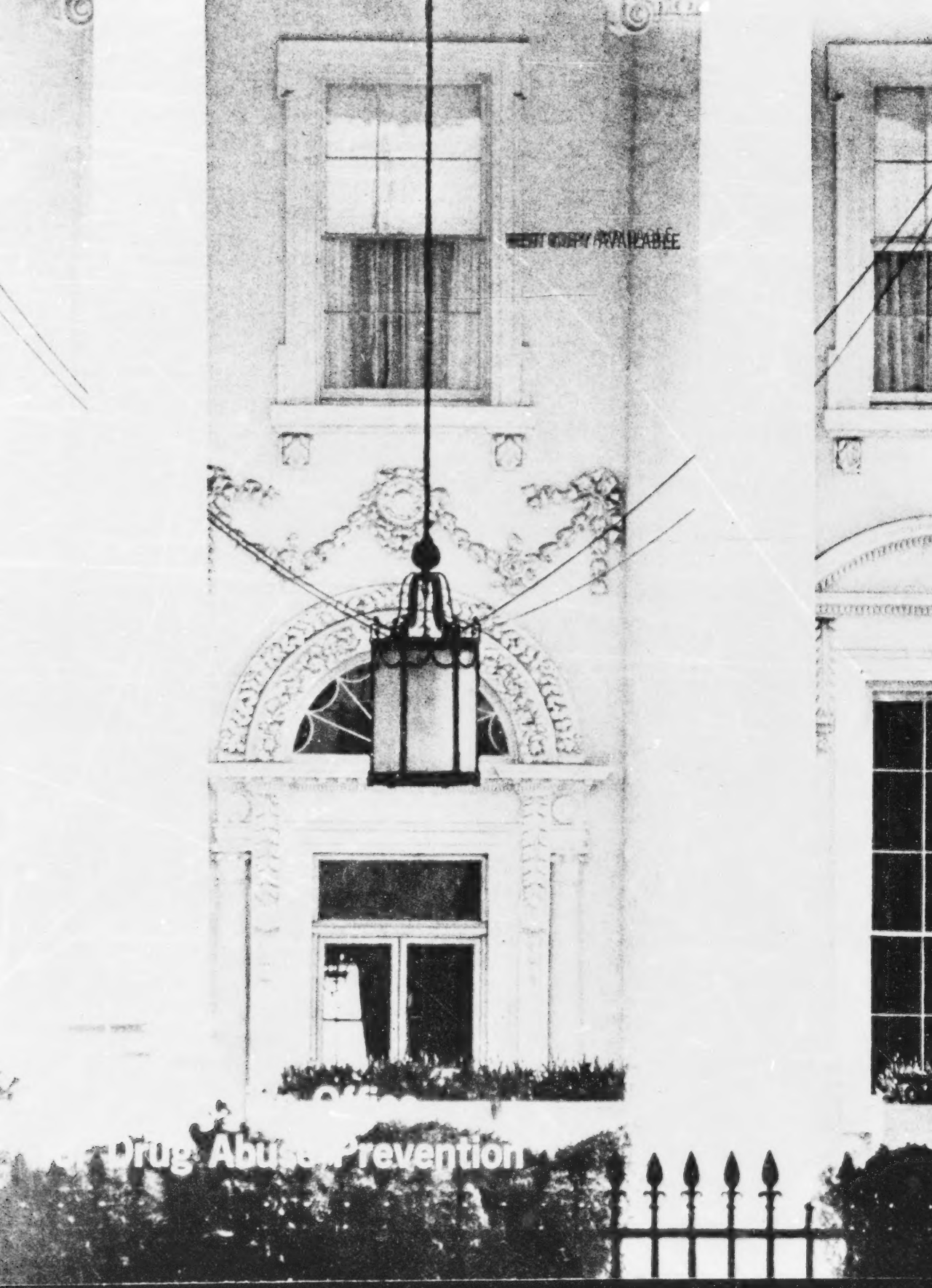

The Federal Government recognized the existence of a drug problem in this country nearly 60 years ago. Early Government response, embodied in the Harrison Narcotic Act of 1914, was directed almost exclusively at controlling the supply of dangerous drugs. The Harrison Act established Federal control over the supply, distribution, and use of narcotic drugs in the United States, imposing strong legal penalties for illicit possession or sale of narcotics. But almost no attention was given at the Federal level to the treatment and rehabilitation of drug users until the early 1930's, when the U.S. Public Health Service hospitals at Lexington, Kentucky, and Fort Worth, Texas, were established to treat drug addicts. By the mid-50's many locally supported treatment programs had been established across the country.

The high rate of relapse by addicts after treatment indicated a need for better understanding of the problems of rehabilitation, new methods of treatment, and far greater attention to prevention and education. Throughout the 1960's, the Federal Government underwrote research and experimental programs of all kinds in the field of drug abuse. The Office of Economic Opportunity in 1967 initiated community-based programs for treatment and rehabilitation of addicts in poverty areas of major cities.

By the end of 1968, a number of Federal agencies were engaged in drug abuse prevention activities, and more were entering the field. Some were concerned mainly with treatment and rehabilitation, others with research and education. Some agencies carried out programs themselves, and many gave financial support to projects operated by universities or private groups. It became increasingly clear that there was an urgent need for coordination of the Federal effort, to avoid duplication and to bring coherence to the growing number of programs under Federal support.

Accordingly, in the late fall of 1970, President Nixon created a White House Task Force of experts and consultants from outside the Government to make recommendations on how the Federal Government could best focus its resources to cope with the many problems of drug abuse. Acting on these recommendations, the President undertook to develop a single coordinating agency at the highest Federal level. The Special Action Office for Drug Abuse Prevention in the Executive Office of the President is the result of this effort.

Dr. Jerome H. Jaffe, the Chairman of the White House Task Force, was asked by President Nixon to become Director of the Special Action Office in the summer of 1971. He was replaced by Dr. Robert DuPont in June 1973.

The Special Action Office for Drug Abuse Prevention was established by President Nixon under an Executive Order on June 17, 1971. Legislation formerly creating the Office, the Drug Abuse Office and Treatment Act of 1972, was enacted by Congress in a unanimous vote, and was signed by the President on March 21, 1972.

The basic mission of the Office is twofold. First, it is directed to take immediate steps to reduce drug abuse in the United States within the shortest possible time. Second, it has the responsibility for developing a comprehensive long-term Federal strategy to combat drug abuse. The President and the Congress have directed the Special Action Office to exercise broad authority to accomplish these vital tasks.

The Special Action Office is not intended to fund or operate ongoing programs, although it may develop and demonstrate promising new concepts and approaches to problems of drug abuse. The Director reports directly to the President.

The Special Action Office authority covers all Federal programs or activities relating to drug abuse education, training, treatment, rehabilitation, and research, irrespective of the agencies which run them. There are 19 Federal departments and agencies now engaged in the non-law enforcement aspects of drug abuse prevention. Seven are concerned with treatment, nine with rehabilitation, four with training, nine with education, four with evaluation, and seven with research.

A major Special Action Office task is to coordinate the efforts of these agencies, evaluate their performance in programs related to drug abuse, and work with them to improve services.

The long-term assignment of the Office includes an analysis of the nature, extent, and trends of drug abuse in the United States, and an examination of the various approaches to solving the drug abuse problem in order to develop effective action programs. Most important, the Special Action Office sets goals, establishes priorities, and specifies how Federal resources of funds, programs, services, and facilities shall be used to combat drug abuse in the United States.

Action Priorities

Two major target groups are receiving urgent ttention—heroin addicts who commit a signifiant portion of all urban crime, and the growing umber of young drug abusers. Priorities for the ork of the Office emphasize new initiatives in the eld of drug abuse prevention and treatment.

Under the Act which created the Special Action ffice, the Director has the following responsibilies:

A. Provide overall planning and policy, and stablish objectives and priorities for all Federal rug abuse prevention programs.

B. Review the regulations, guidelines, requirements, criteria, and procedures of operating agencies to assure consistency with national drug buse prevention strategy.

C. Examine and evaluate related Federal legisation, budgets and programs, and recommend hanges in organization, management, and personnel, where appropriate.

D. Develop and demonstrate more effective rug abuse prevention programs.

E. Encourage and promote expanded research rograms and clinical research facilities.

F. Coordinate Federal programs with the drug revention activities of State and local governments, public and private agencies and individuals, and provide technical and professional assistance.

G. Foster drug abuse prevention, treatment, nd rehabilitation programs and services in State nd local governments and in private industry.

H. Submit an annual report to the President n the activities of the Special Action Office.

The final responsibility of the Special Action ffice is to prepare for its own orderly phase-out y June 30, 1975.

Marks of Progress

Significant progress is being achieved in dealng with drug abuse problems.

• Increased Federal funds and new techniques o secure them have been approved to fight drug buse. Since 1969, Federal support has increased ourfold for research, sixfold for treatment and ehabilitation, and thirtyfold for education and aining.

• Treatment and rehabilitation continues as he first priority. Between June 30, 1971, and une 30, 1972, the number of Federally funded treatment programs in operation increased from 135 to more than 320. Nearly 90 began operation in the last three months of FY 1972. In terms of patients in treatment this meant an increase from 16,000 in June of 1971 to more than 51,000 on August 30, 1972—more than tripling. Expansion of treatment has resulted from close coordination between SAO and other agencies. It also reflects the development of more efficient start-up procedures by SAO. Fee-for-service contracts, keyed to cost and quality standards, and targeted on geographic areas of greatest need have been a major innovation.

• The Special Action Office has scrutinized the budgets and evaluated the policies of all civilian Federal agencies engaged in drug abuse prevention, excepting those offices dealing with law enforcement. It has worked with each agency to establish specific goals and shape budgets to achieve them. A system to monitor and evaluate these efforts has been organized.

• New programs were developed to reduce abuse among GI's in Vietnam, and at other bases overseas and at home. Military policy has shifted to treat drug abuse as a medical problem—not simply as a disciplinary problem. A massive screening program has been set up to detect drug abusers who are then provided treatment and rehabilitation services.

• The Special Action Office helped conduct a nationwide review of all the methadone maintenance programs in the United States, and the status of the drug has been changed from a research tool to that of a recognized form of medical treatment, under strict Government controls. Increasing numbers of addicts are voluntarily seeking this treatment, and programs are being expanded to accommodate them.

• With the help of the National Bureau of Standards, the Special Action Office has developed a technique to prevent the diversion of methadone to illicit channels, yet protect the anonymity of those under treatment. To reduce the possibility of diversion, a longer-lasting methadone is under development.

• The Special Action Office has expanded the education and training of those who are dealing with the nation's drug abuse problems, including teachers, medical personnel, and laymen. The National Drug Abuse Training Center established in Washington, D.C., will train people in the new-

est techniques of drug abuse prevention. Other Federally-supported centers will train persons to teach new skills to others in their communities. Through the U.S. Office of Education, all 50 states will be helped to strengthen their own drug abuse prevention efforts.

- Through new grant programs operated by the National Institute of Mental Health, the Special Action Office is assisting medical schools to expand their course work in drug abuse problems. Physicians and other medical professionals are being trained in the latest techniques for drug abuse diagnosis and treatment.
- New technical assistance in combating drug abuse is being offered to the states. The Special Action Office has assembled teams of professionals to help communities with special drug abuse problems, and to set up demonstration programs. The National Clearinghouse for Drug Abuse Information is being expanded to offer the latest information in the drug abuse field to professionals and others. On request, the Clearinghouse furnishes information on medical and educational techniques and offers suggestions on how to establish local drug abuse programs.
- A master reporting system to collect data on all kinds of drug abuse is being organized. New programs have been started to gather information on the amount and patterns of drug abuse, and to note shifts in trends of usage.
- Because nearly half of all street crimes committed in the United States are thought to be drug-related, the Special Action Office has developed a new concept to provide treatment alternatives to drug abusers who are arrested. They are offered methadone maintenance and other forms of treatment, to break the drug addiction—street crime cycle. In cooperation with the Law Enforcement Assistance Administration, the concept is being implemented in a number of metropolitan areas.
- Research has been stepped up in a variety of drug abuse areas. New and more effective narcotics antagonists are being tested; simpler ways of screening for drug abuse are under development; studies are under way to determine the implications of long-term use of marihuana. Morphine and heroin are being restudied for possible physical dangers that may not have been recognized. New studies are being conducted to find out what moves some people to voluntarily give up drugs, and on educational techniques to prevent them from starting at all.

Looking Ahead

Along with its mandate from the President and from Congress to control today's drug abuse epidemic "in the shortest possible time," the Special Action Office is also instructed to plan for the future. In this task, it provides the staff for the Strategy Council, established along with the Special Action Office under the 1972 Drug Abuse Office and Treatment Act.

The Council is a permanent group made up of heads of the key Federal agencies responsible for drug abuse programs. It aids the Special Action Office in the development of long-range Federal policy on drug abuse and is responsible for continuing that policy after the phase-out of the Office.

The Council ties together the health and medical aspects of drug abuse programs with the law enforcement efforts to eliminate illicit drug supply and traffic. It operates on the principle that law enforcement must be coupled with a rational public health effort to prevent drug abuse and to detect, treat, and reclaim the drug abuser.

With the help of the Special Action Office, the Council encourages all Americans to join in the fight against drug abuse—not only doctors, scientists, nurses, and teachers, but parents, students, businessmen, and citizens from all walks of life. It asks all parts of the community—churches, schools, civic groups, and business—to mobilize their resources for effective action.

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555 W. 57th St. Suite 1900
New York, N.Y. 10019

REGION 3
Drug Enforcement Administration
600 Arch Street
Room 10224
Philadelphia, Pennsylvania 19106

REGION 4
Drug Enforcement Administration
31 Hopkins Place
Room 955
Baltimore, Maryland 21201

REGION 5
Drug Enforcement Administration
201 N.E. 12th Street
Miami, Florida 33132

REGION 6
Drug Enforcement Administration
357 Federal Building and U.S. Courthouse
231 W. Lafayette
Detroit, Michigan 48226

REGION 7
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219 South Dearborn Street
Everett Dirksen Federal Office Building
Chicago, Ill. 60604

REGION 8
Drug Enforcement Administration
1001 Howard Avenue
Suite #1800
New Orleans, Louisiana 53202

REGION 10
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Suite #231
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REGION 11
Drug Enforcement Administration
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REGION 12
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U.S. Customs House
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Denver, Colorado 80201

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DEA/Justice
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